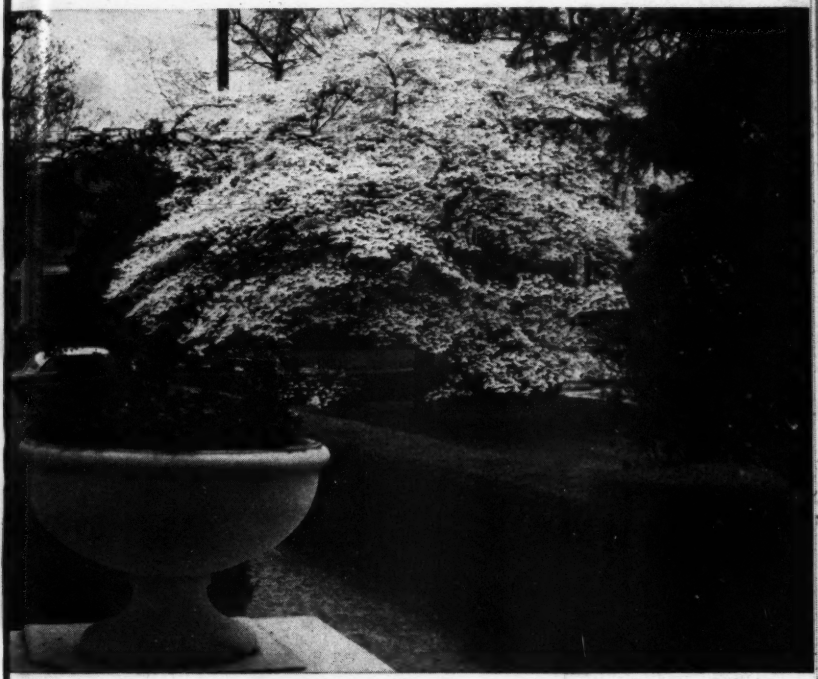
Oral Hygiene

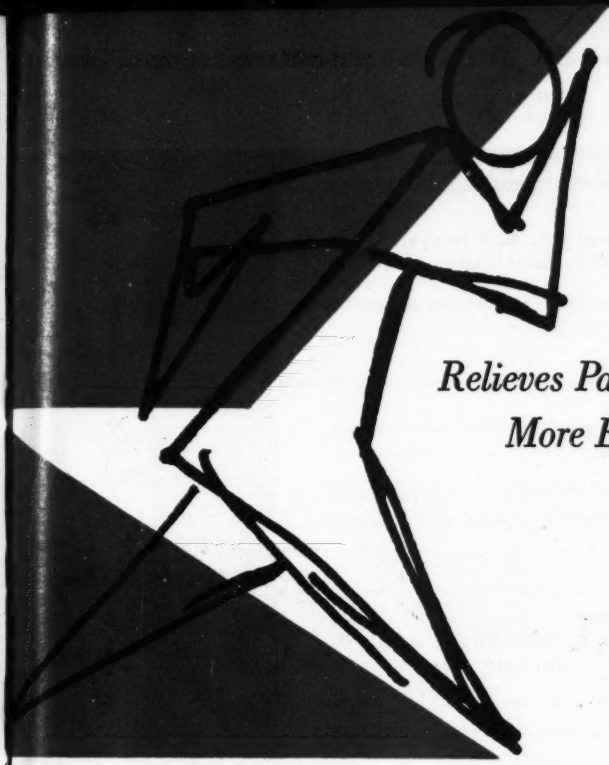
FEBRUARY 1957



Dogwood tree blooms in yard of Charles Walthour, Atlanta, Georgia, host city to The Thomas P. Hinman Mid-Winter Clinic, March 17 to 20.

In this issue:

I WAITED TOO LONG FOR INSURANCE



Relieves Pain Faster, More Effectively

A combination of analgesics, such as aspirin, acetophenetidin, and caffeine has been clinically proven to exercise a smoother and more effective action than equivalent doses of any one used individually.[1,2] Anacin is such a formulation. Anacin acts quickly to raise the pain threshold and affords prolonged relief. There is no gastric upset—Anacin does not upset the stomach. Faster-acting, long-lasting, better tolerated—this greater total effect in pain relief is why more dentists prefer and recommend Anacin than any other analgesic.

always **ANACIN**®

for better relation between dentist and patient

References: 1. Hammes, E. M., Jr.: *Journal-Lancet* 72:67, 1952. 2. Goodman, Louis S. and Gilman, Alfred: *The Pharmacological Basis of Therapeutics*, second ed., 1955.

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S. S. White Casting Golds

NO. 900 **Type A, Soft Inlays, Coin Gold Color**

Ideal for inlays subject to moderate occlusal stress. Easily burnished.

NO. 820 **Type B, Medium Hard Inlays, Light Coin Gold Color**

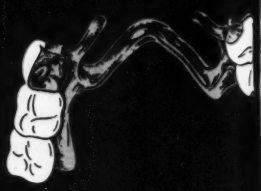
Strong, yet burnishable. For m.o.d. and ordinary inlays, ¾ crowns, pontics and posterior abutments.

NO. 13 **Type C, Hard Inlays, etc., Dark Coin Gold Color**

For hard inlays, thin ¾ crowns, incisal angles over facings, slice preparations, pontics and anterior bridge abutments.

NO. 3 **Extra Hard, Coin Gold Color**

For all types of bars, partial dentures, ¾ crowns with thin walls, m.o.d., inlays, cast cusps and abutments.



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Philadelphia 5, Pa.

The Publisher's CORNER

By Mass

No. 427

Highway Homicide

MAGAZINES in all fields (including ORAL HYGIENE) have been urged to help campaign against motor murder. Last summer I wrote on the subject for another magazine and am going to quote from that article now, and from still another article I wrote about highway homicide a few months before. The dreadful facts are the same, year after year. The arithmetic changes, but the facts are always horrible. The Travelers Insurance Company has been and is very active in the campaign, but is obliged to admit that "despite all the safety campaigns, the shameful record of heedlessness and disaster on our highways continues to unfold. The fatal fallacies of over-confidence and lack of judgment take their terrible toll." Last year (1955) was a record year for motor murder. The 1956 figures are not yet available.

Here are the grim statistics. There were 37,800 deaths—2,300 more than in 1954. And more than two million people were

February 1957. Monthly. Oral Hygiene, Inc., 1005 Liberty Ave., Pittsburgh, Pa. Subscription. $5.00 a year in U.S., Canada and Latin America; $5.75 elsewhere. Accepted as controlled circulation publication at Rutherford, N.J.

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Sal Hepatica®

Since 1897, pharmacists have been dispensing SAL HEPATICA—the fast-acting yet gentle laxative.

Because sparkling SAL HEPATICA is both antacid and effervescent, it passes rapidly through the stomach. In the intestine it provides fluid bulk by its osmotic action. This bulk stimulates peristalsis. Prompt evacuation usually follows—within an hour, if taken before breakfast—before bedtime, if taken half an hour before the evening meal.

SAL HEPATICA is pleasant-tasting, acts without griping, therefore is liked by patients. Because it is antacid, it relieves the gastric hyperacidity frequently accompanying constipation.

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injured—2,158,000 to be exact—198,000 more than in 1954.

Speeding accounted for 715,000 casualties. Pedestrian casualties furnished the only "bright spot" in the record. The 230,400 pedestrian casualties were 4,600 less than in the previous year.

Are you still with me? Can you stand a few more slaughter statistics? Here they are: over 15,700 deaths occurred on week ends—more than 41 per cent of the total. About 27 per cent of the drivers involved in fatal accidents were under 25 years of age.

About 85 per cent of the vehicles involved in fatal accidents were passenger cars. Some 22 per cent of the deaths occurred on Sunday. The most dangerous hours of the day are said to be 4 to 8 P.M.

Saturdays and Sundays are the dangerous days—last year became days of "permanent rest" for 13,980 motorists. Nighttime is the worst time.

Dry roads and good weather seem to encourage dangerous driving. About half the accidents were caused by excessive speed. High in the list of causes were reckless driving and driving on the wrong side of the road.

New drivers weren't the only ones to blame; 97 per cent had been driving for more than a year. Male drivers were blamed in 91 per cent of fatal accidents.

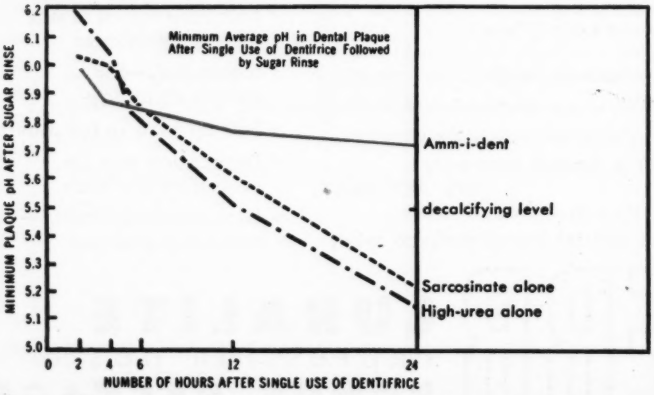
What is the reason for motor murder? Here it is: we are building fine new cars and fine new roads—*but the same old kind of people.*

Maybe we'll write some more on this subject. Have you any suggestions?

the Greatest "OUNCE OF

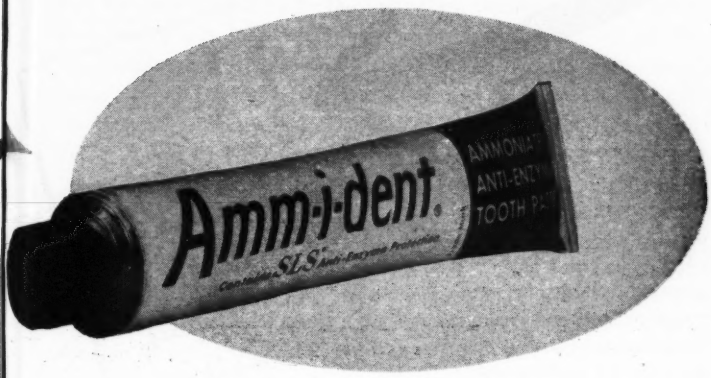
The only dentifrice combining anti-enzyme and ammoniated action for greatest caries protection!

Only Amm-i-dent contains SLS and high-urea—which work synergistically to give patients 24-hour protection against tooth decay. The chart below shows the all-day effectiveness of Amm-i-dent which contains these two ingredients to prevent acid formation, as compared to the much shorter protective span afforded by either one alone.



SLS is Amm-i-dent's trademark for Sodium N-Lauroyl Sarcosinate

PREVENTION"



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Paste with high-urea and SLS for ammoniated and anti-enzyme action.

Super Amm-i-dent
Paste with high-urea and SLS, plus sodium fluoride for hardening action.

Green Amm-i-dent
Paste with high-urea and SLS, plus non-staining chlorophyll.

Also available—ammoniated Amm-i-dent Powder, white or green (chlorophyll).

TASTES GOOD Amm-i-dent tastes good, is an excellent cleanser. Patients like its flavor and pleasant foaming action. Try it—you'll like it too.

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Each capsule contains:

Thiamine Mononitrate (B_1)	10 mg.
Riboflavin (B_2)	10 mg.
Niacinamide	100 mg.
Ascorbic Acid (C)	300 mg.
Pyridoxine HCl (B_6)	2 mg.
Vitamin B_{12}	4 mcgm.
Folic Acid	1.5 mg.
Calcium Pantothenate	20 mg.
Vitamin K (Menadione)	2 mg.

Write for information and prescription pad.

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HU–FRIEDY

Announces New Facilities for Increased Instrument Production

For the past several years the increasing demand for Hu-Friedy instruments has been straining the production capacity of the Hu-Friedy factory in Chicago to its utmost, hence the delivery of some types of instruments has been necessarily delayed. The many Hu-Friedy instrument users in the profession, who have experienced delays in shipment, have been loyal and patient. Delay in shipment, however, is not in the tradition of Hu-Friedy prompt service.

The company is now very happy to announce the establishment of new instrument manufacturing facilities in St. Petersburg, Florida. Under the supervision of Mr. Hugo Friedman, President, and the direction of an outstanding engineer and metalurgist the same traditional high quality of Hu-Friedy instruments will be maintained. The same high degree of skilled craftsmanship and the same high quality of materials will continue to go into every Hu-Friedy instrument.

These new facilities added to those of the Chicago factory will eliminate much of the gap that now exists between demand and production. This added production will enable the company to render much better service to Hu-Friedy customers through their dental dealers throughout the country.

In making this announcement the company expresses its appreciation to the thousands of dentists whose loyalty and friendship have made this important development possible.

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COMPARE films from
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All Kodak Radia-Tized Dental X-ray Film is now *twice as fast!*

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Look closely at the two radiographs enlarged from the full-mouth examinations shown above. Same high quality, but the new film had one-half the exposure.

For all dentists, the doubled speed means less likelihood of blurring due to patient movement during exposure—hence better radiographs.

For all patients and operators, the new film means a resultant reduction in radiation.

And for dentists who prefer 8″ focus-film distance, here's an ideal recording medium with one-half the former exposure and no impairment of quality.

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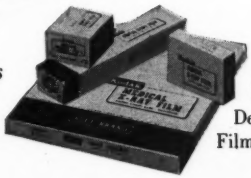

Use Kodak Dental X-ray Film . . .

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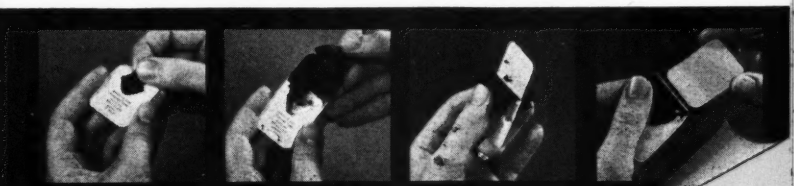

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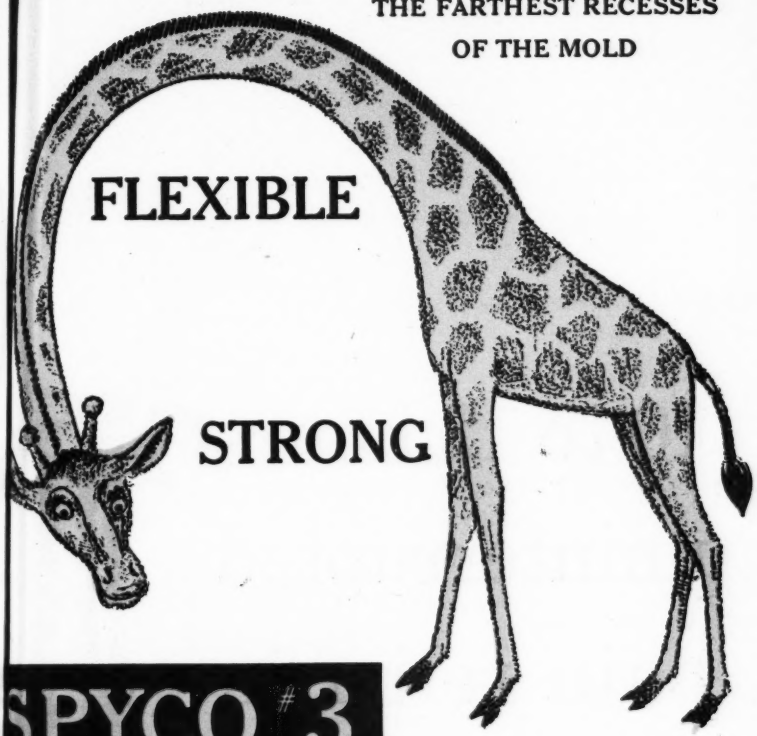

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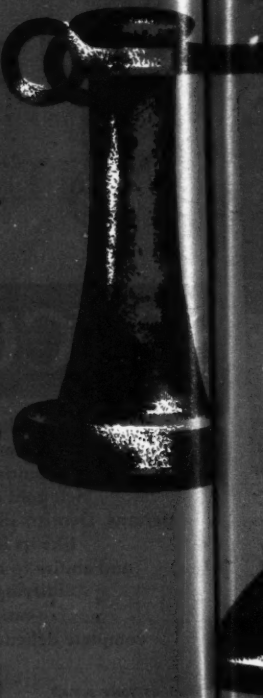

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Hyoscine Hydrobromide	0.0195 mg.	0.0195 mg.
Phenobarbital	48.6 mg. (¾ gr.)	48.6 mg. (¾ gr.)

1. Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, N. Y., The Macmillan Co., 1955, p. 127.

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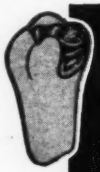

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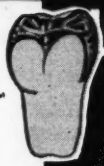

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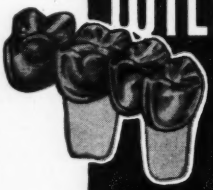

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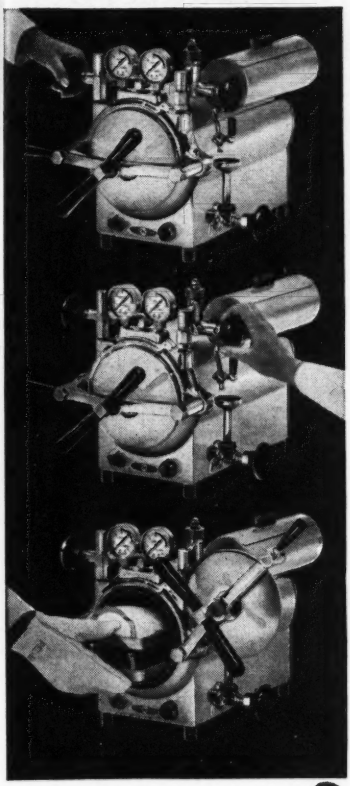

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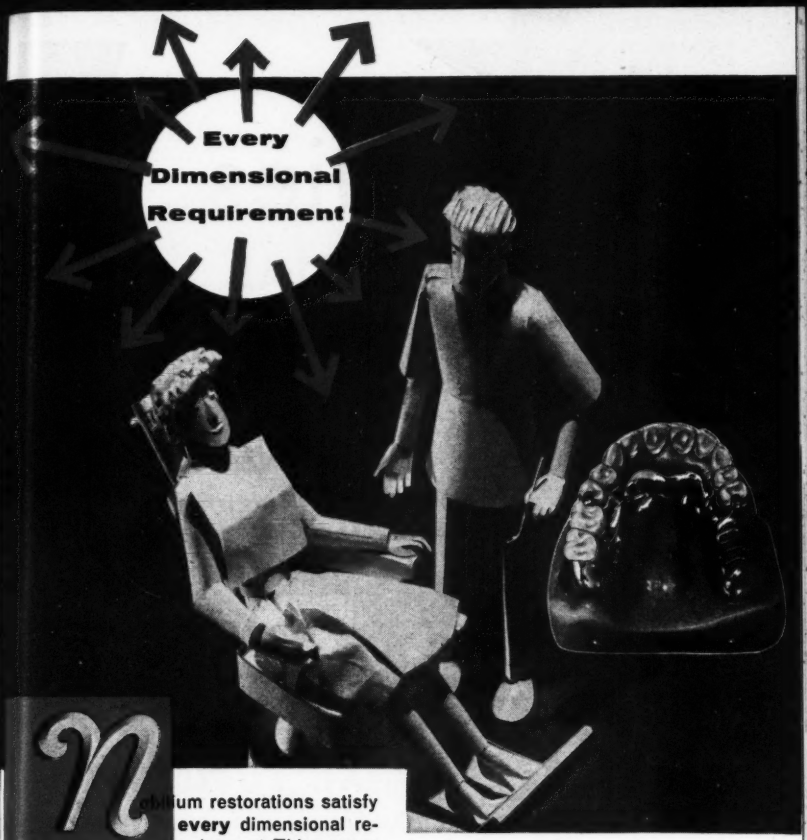

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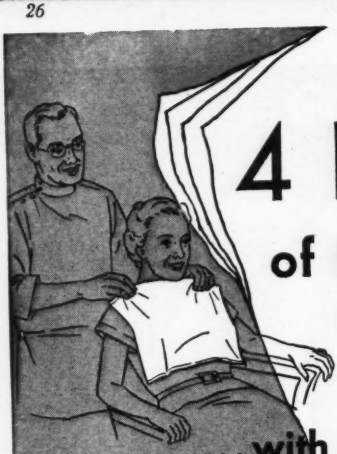

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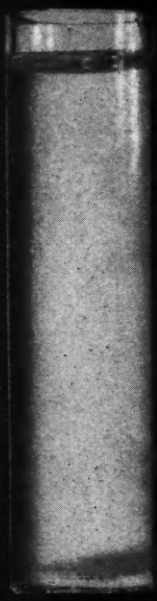

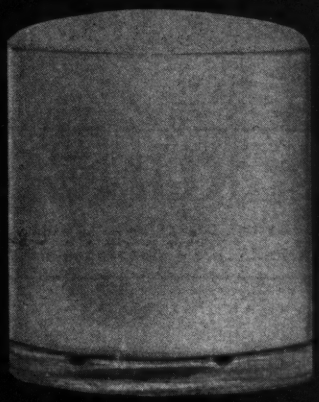

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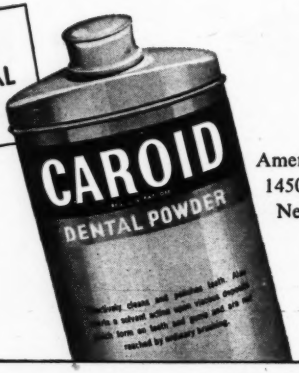

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1. Stieglitz, E. J.: in Modern Nutrition in Health and Disease, ed. by Wohl, M. G. and Goodhart, R. S., Lea and Febiger, Philadelphia, 1955, p. 945.

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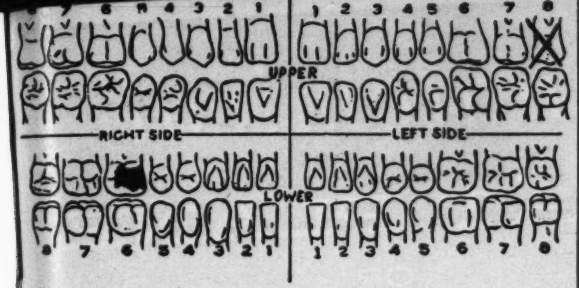

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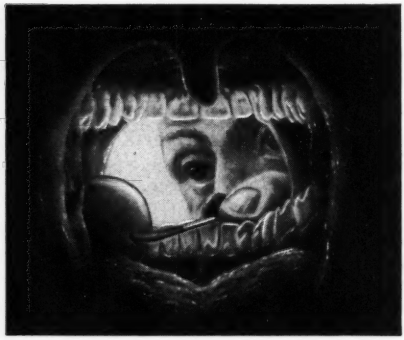

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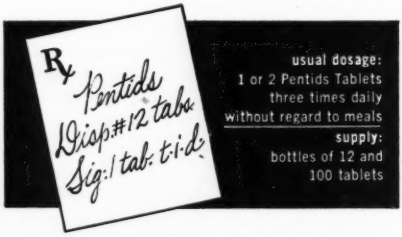

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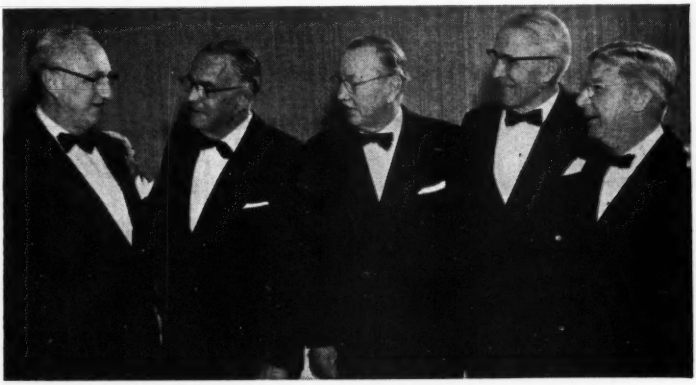

DENTAL ALUMNI of the Mayo Clinic at a reunion in Rochester, Minnesota (Left to right): Daniel F. Lynch, Washington, DC; Boyd S. Gardner, Mission, Texas; Edward C. Stafne and Louis T. Austin of the Mayo Clinic; and Harold W. Krogh, Washington, DC.—*Photograph from Rochester (Minnesota) Post-Bulletin.*

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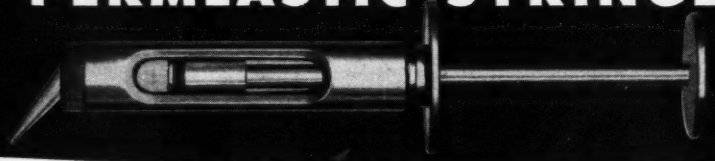

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I Waited Too Long For Insurance

BY ROBERT A. WEISSBURG, DDS

You need the protection of life insurance—disability, old age, or death may cut off your income at any time.

I WANT to buy $58,000 worth of life insurance right now. I want to buy it, because without it my wife might lose our home; my little girl suffer being raised in city slums; and my young son leave school to do menial work the rest of his life. Pretty powerful reasons for wanting $58,000 of life insurance, don't you think? And I cannot get it. No company on earth will sell it to me. I waited too long.

Yes, I would buy it today. I could have bought it a short time back. But when you can get it, the need for it is not as sharply defined, and the actual purchase many times is postponed or dropped because we dentists of America fall prey to some old clichés about this greatest of all family protection and investment combination—life insurance.

Did you ever hear or read the advice to "Buy stocks and real estate that fluctuate with the purchasing power of the dollar, not life insurance whose cash values are constant." And when you were mulling that through, did you wonder where the logic in the statement was for the fellow who wanted to retire during a depression, or a widow who was left real estate and because of the economy found it a liability instead of an asset? Certainly most of you at one time or another have been advised by well-meaning theorists to "Buy term and invest the difference." Or "to depend on your savings during periods of disability rather than pouring out money to a life insurance company for income protection."

Yes, when you are well and hearty these clichés form a warm little nest to escape the main issue —*the need for life insurance!*

Since I realize that is what happened to me, I must take this step to protect my colleagues. These clichés, while logical in theory, in true life are dead wrong and will *hurt* you bitterly and those you love.

I know! Let no one argue that point. For I am exhibit "A." I was a dentist who gullibly followed such advice until a disaster changed theory into reality for me, and I found theory fell angonizingly short. Just ten years after I entered the practice of dentistry, and at a time when I seemed to have life's immediate financial problems licked, at the age of 33, I suffered a complete paralysis of my left arm and leg. Wake up colleagues—these things do happen! You *can* become disabled, and get old. I did. It happened to me.

Now with that possibility in mind, please focus out the life insurance men you keep dodging and focus in their product—life insurance. Ask yourself a question: How much are you going to earn between now and retirement—$200,000, $400,000, $800,000? What can keep you from earning it—death, disability, old age? If you die, how much money will your family have—$20,000, $30,000, $80,000? And just how can *your* family survive on 20 per cent of your income? And if you are the next dentist to lose your ability to continue your practice through accident or illness, how many of those hundreds of thousands of dollars have you insured yourself for—$400 per month for two years totaling $10,000, or is it $20,000, or $30,000? Ask yourself and see if the answer really sounds like much now when compared with $200,000 or $800,000. Then review your stock reply to rid yourself of the men who sell the only product you can rely on to safeguard your most valuable asset—your ability to work—against the only three things you have to fear financially—disability, old age, and death. "I'm overinsured—worth more dead than alive." Doesn't sound quite so glib now, does it, Doctor?

Insure the Irreplaceable

Why do we insure our equipment? The loss or damage is a replaceable loss; yet there is not one of us who fails to see the need for protection from a loss such as this. However, as in my case, the loss of the use of just a hand makes your equipment and your practice valueless. You are then no better than a new unit destroyed by fire. Your practice cannot run without you. Your life and skill are your means of practicing. Your body is the machine that makes practice possible, and should be the one to be protected in the best way possible.

I was not able to practice for two years. My family and I had always lived well. Then came an experience that I hope none of you ever have to live through. Where will the money come from? I lay awake night after night worrying.

I will not relate further my own horrible day of reckoning, except to warn you that when it happens —when the theory changes into your actual day to day living—you approach the problem from a far more discerning angle; suddenly it is *you* against financial chaos, and all the well-meaning but personally inexperienced theorists leave you behind with your agony while they run ahead to continue guiding the healthy and the gullible.

Who Invests the "Difference"?

We dentists do not have time to become investment experts. When life insurance companies give us a chance to convert our term insurance into ordinary life we had better pour our extra dollars into it. To get the same return from any other investment, after taxes, we would have to be guaranteed about five per cent. Buy term and invest the difference we are regularly advised. But you and I know that most often we do not really take the difference and invest it. And if we did, where could we be guaranteed 5 per cent without any effort on our part? Too many dentists end up life in poverty to argue about this point.

The old argument about buying term and investing the difference is a chestnut that has been kicked around for years, with the only concrete result being the despair of thousands of insurance purchasers who follow it.

The conclusion of the old line is carried out by the advice that after years of "investing the difference" this theoretically anticipated accumulation should be used to purchase a life annuity. This advice is more easily displayed as lacking real life logic by merely acquainting yourself with two facts: First, life insurance companies are not primarily in the annuity business, and thus they knowingly penalize people who wait until they are 60 or 65 to purchase their annuities. Second, all permanent insurance (not term) offers the annuity feature at much less cost. Thus, those who purchase whole life insurance rather than the term and annuity combination gain this advantage.

Any high school student is aware that longevity continues to increase with each of our medical advances. Annuity tables are based on mortality tables currently being used. A man who buys whole life insurance at age 30 in 1956 has a mortality table based on 1956 guaranteed to him. The other chap who waits until he is 65 and buys an annuity in 1991 will buy one based on a mortality table at that time. And it is not too radical to anticipate that such delay will mean it costs him half again as much to do the same job.

Yes, fellow dentists, there are three things in this life that can financially sink you: losing your ability to work, old age, and death; and the life insurance industry offers most of us the *only* solution to all three of these problems. So do

not approach this lifeboat on gossamer wings and timid advice. Find yourself a qualified life insurance adviser in whom you have confidence and stay with him.

I believe this advice is borne out by the fact that since my disability awakenend me to the financial facts of life, I have become associated with a firm whose purpose is to determine that whatever happens to its clients they will be financially ready for it.

If anyone believes I have been too strong in my criticism of ethereal advice, let him realize once again that I too was a follower of this advice to the extent that in my desk drawer I still have today a life insurance application completely and carefully filled out by a qualified life insurance adviser. One week before I was struck down, I placed it in my desk drawer *unsigned*, while I pondered the advisability of taking this $58,000 of life insurance along with $580 per month of lifetime disability income—pondered not on the advice offered by the qualified agent, but rather on the advice offered by the scores of articles I had read by so-called disinterested third party advisers. The now worthless piece of paper, which could have been transformed miraculously into $580 per month every month as long as I lived, if I had signed it instead of placing it in the desk drawer that fateful day, serves as a constant reminder to me of an opportunity lost. I have had plenty of time since to consider all the angles the experts advise you to watch for before buying life insurance, but the only advice I would heed today would be that of the qualified life insurance man who so candidly told me that day: "You need it because you are either going to get old, or die, and in between you may become disabled. Don't wait, because something can happen to you today as well as any day in the future."

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COLUMN ON TEETH GAINS POPULARITY

YOUR TEETH, a new weekly column by Doctor Peter Garvin of Cincinnati, Ohio, has won considerable reader interest according to reports of General Features Corporation of New York. Doctor Garvin's column has been running in the *Ohio State Journal*. Mr. Harold W. Carlisle, executive editor, reports that the public acceptance is surprising, since he does not expect such reaction from any weekly feature—which proves that the average reader is more interested in his own teeth than in politics or world affairs.

Have the Patient Sign a Contract

BY WILLIAM H. ALLEN, JR, LLB

A short written contract on the patient's permanent record card will avoid misunderstandings and the cost of collecting delinquent accounts.

THE CONSCIENTIOUS dentist, like the conscientious physician, must of necessity extend credit to poor credit risks, and do a rather extensive credit business whether he wishes to or not. He cannot in good conscience refuse to treat a patient who is in real need of dental attention simply because of the patient's inability to pay cash at the time of treatment. Because this is true, the dentist often finds himself at the mercy of the unscrupulous, and finds that his very conscientiousness makes him a target for those who would take advantage of his sense of moral obligation and his desire to help relieve the sufferings of his fellow men.

There is little, if anything, that the dentist can do to change the nature of his business so that he will not be forced to extend credit to poor risks; but there is a means, and a fairly simple and effective one by which he can protect himself against those who would take

advantage of him without making any effort to pay him for his services at a later date. The dentist can protect himself by requiring every new patient to sign a simple contract promising to pay for the services rendered, and setting out any other terms or conditions that he desires. If this requirement is made a matter of policy and is required of everyone it will not arouse any opposition or antagonism. As a practical matter, this contract should consist of a few lines of fine print at the bottom of the file card that is kept as a part of the permanent record of every patient.

There are several advantages to making such a contract a part of your business policy and incorporating it into your permanent record:

First, this contract will offer tangible evidence of the service performed, and will show that the patient agreed to pay for it according to the dentist's regular fees. This will help to eliminate misunderstanding over fees between dentist and patient. If a written record containing the patient's signature and an agreement to pay is kept for every patient, misunderstanding is not so likely to occur; and if it should arise, it will be more easily resolved. Misunderstandings can be costly in terms of friendship and good will, and in some cases may lead to legal battles which can be even more costly in terms of court costs and attorney's fees.

A written contract is no guarantee that there will be no law suits, or that it will be unnecessary to turn any accounts over to a bill collector; but it will help to keep both at a minimum. In the event that it is necessary to take legal action to force the payment of an account, the fact that there is a written contract will facilitate proof of the account. There can be little dispute when there is a contract signed by the debtor for the court and the jury to see.

Another good reason for requiring patients to sign a written contract as a matter of policy arises in many states under what is known as the "Dead Man's Statutes." Although these statutes may vary considerably from state to state, they all do essentially the same thing: they prohibit the giving of oral testimony against the interests of a dead person. Suppose, for example, that you have been working on a new set of dentures for Mr. Taylor. You have almost completed them, and have incurred considerable expense in laboratory fees, when Mr. Taylor is killed in an automobile accident. If there is no question concerning the denture you have nothing to worry about, but in the event Mr. Taylor's executor questions the account, or a dispute arises, how are you going to prove the account? In the absence of a written contract of some description it would be difficult to do.

An additional reason for requir-

ing the patient to sign a written contract is that in most states the statute of limitations is longer on such a contract than it is on an open account. A written contract can go for several years without payment, and can still be collected through the courts if necessary.

Avoid Collection Costs

So far as the dentist is concerned, the important reason for requiring the patient to sign a written agreement is to facilitate the collection of accounts, and to put any costs of collecting delinquent accounts on the patient where they belong. The dentist must of necessity do a large percentage of his practice on a credit basis, but there is no reason why he should not protect himself by contract from some of the expense of collecting past due accounts from people who do not live up to the trust that is placed in them. Attorney's fees for collecting may also be looked on as part of the expense of collecting and placed on the delinquent patient. The dentist will be saved a good deal of expense if he can collect some of his delinquent accounts without having to bear the costs of collection.

The contract can also provide for the waiver by the patient of some of the property exemptions that are given by law. In this way the delinquent debtor can be kept from hiding behind the law to keep from paying a perfectly legitimate and just dental statement.

The contract that you use need not be a complicated instrument. As a practical matter, it must be quite simple and consist of a few lines of fine print that will fit in at the bottom of the file card, which is kept as part of the permanent record on every patient. The contract should state that the patient agrees to pay for the services received, according to the regular fees charged by the dentist for such treatment. The statement can also set out any other terms and conditions you deem advisable. You know your procedures and your particular problems better than anyone else. You know what terms and conditions you want your contract to include. The following sample statement is given here as a suggestion and guide. You may use it as is, or you may vary or adapt it to suit your needs. If you are in doubt as to anything you feel it might be wise to add, I would suggest that you consult an attorney and ask him to draft a contract statement to go on your record file card. His charges for a simple contract will be small, and the contract he will draw up may save you a great deal of money in the future. If you have no special problems or requirements, the sample suggested here should be adequate for you. It is as follows:

"I hereby agree to pay for all dental service performed on me by Doctor ..... at his regular fees within 30 days from the time the service is completed or

on terms satisfactory to him. I waive as to the payment of the total amount due all rights of exemption under the Constitution and laws of the State of ....., *as to personal property, and agree to pay all costs of collecting the amount due or to be due, including a reasonable attorney's fees.*

Signed ....."

It is wise business policy for the protection of all concerned to incorporate a contract into your record card and to require all new patients to sign it. It will help to avoid misunderstanding and may save you money in the future. Written contracts are used by others in every imaginable type of business. Why not use them to protect yourself in your dental practice?

Route 1
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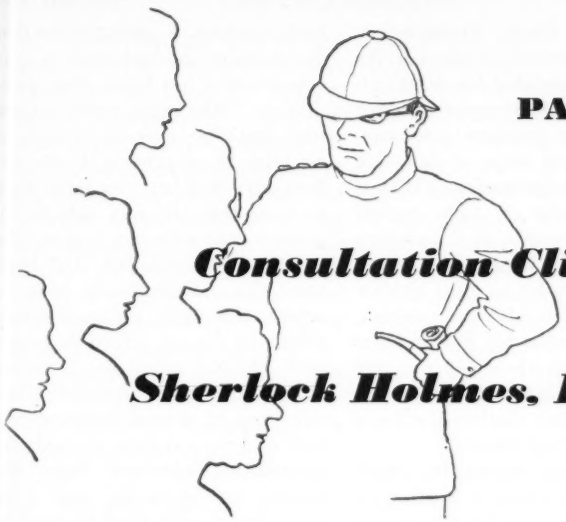
"HELP YOUR MIND TO HELP YOU"

THE MANNER in which a person reacts to everyday situations largely displays the state of his mental health. In other words, his attitude to a given situation, whether good or bad, reveals the degree of his emotional maturity.

Worry, frustration, and excessive anxiety, are factors that may, if uncontrolled, bring on or make manifest underlying psychologic disorders. Some persons, through improper training and guidance in their early years, outwardly express a normal mental attitude to everyday living, but, when confronted with one or several incidents of an unpleasant nature, they "blow up." These people, unfortunately, constitute a large segment of our population.

Essentially any virtue carried to excess becomes a vice. A sense of proportion in one person can easily develop into excessive pride. Respect for others, poise, self-confidence, self-discipline, generosity, understanding, and self-reliance, are all positive factors in a well-balanced person, yet these same attributes, if not controlled, can develop into unfavorable characteristics of extreme egoism. On the other hand, excessive humility, self-pity, self-indulgence, selfishness, hypercriticism, and dependence, are factors that express the inferiority complex.

Many physical conditions could be prevented if emotional upsets could be avoided. Facing the facts is important. Many persons develop complexes by "locking up" their disturbing thoughts. These people would be better off to discuss their problems with someone, and thus get them out of their systems and then forget about them.—E. H. Lindstrom, MD, *Montana Health.*



PART V

Consultation Clinic:

Sherlock Holmes, DDS

BY ARTHUR ELFENBAUM, DDS*

THERE HAS always been some difference of opinion among dentists about how much information should be elicited from a patient on his first visit to the dental office. Some dentists feel that knowing the patient's name, address, and telephone number is ample. Armed with this information, they consider themselves ready to go into action; they examine the oral condition of which the patient has complained, and are almost willing to give an estimated fee and proceed with the treatment.

Do not ask unnecessary questions—concentrate on getting the information which will lead to a diagnosis.

Others prefer to hand the patient a stock printed form with a multitude of questions and let him answer them at home, perhaps with the assistance of the rest of the household. Nothing could be more impersonal than a printed questionnaire in an office where close personal relationship between dentist and patient is essential to diagnosis and treatment. A form is a lifeless thing whether or not it is filled out. Patients look upon it as enthusiastically as they regard an

*Doctor Elfenbaum is Professor of Diagnosis and Chairman of the Department at Northwestern University Dental School and Consultant in Diagnosis at the Dental Training Center of the West Side Veterans Administration Hospital in Chicago.

income tax blank. Furthermore, many of the questions asked on the forms recommended for dental offices are entirely inappropriate for the particular problem under consideration, and some of them are downright embarrassing. There is no reason why a male patient should even have to read questions about menstrual difficulties, questions not intended for him. Neither should a respectable young woman, whom the dentist has known since babyhood, and whose entire family he has treated for many years, have to state whether she has ever been treated for "bad blood."

No question should be asked, which does not have a bearing on the patient's reason for the consultation, or on some non-oral condition observed by the dentist and which he considers might be related to the problem at hand. If the patient appears to be uncooperative, it may be that he is trying intentionally to hide information, or he may have calculated that the dentist could not possibly have any use for it. Under no circumstances should the dentist assume the attitude of a prosecuting attorney. The patient is not on the witness stand. It seems redundant to make such statements, but many patients have abandoned a dentist because they have not been spoken to properly.

There are occasions when a great deal of questioning is not called for, and there are others when seemingly endless inquiry, posed with the best of intentions, just leads nowhere. A patient states that the dentures she had made a year ago are now too loose. One question — "Why were your natural teeth lost?" — may be enough to establish the diagnosis. If the patient says that her own teeth were so loose that she was able to remove a few with her fingers, she has stated the solution. The bone resorption has evidently been so severe that the denture-bearing ridges no longer afford any support. On the other hand, precocious alveolar bone resorption in a child has in several instances defied diagnosis despite voluminous information obtained from the family, the physician, and from every imaginable kind of medical laboratory test.

Occupation a Clue

Notches in the incisal edges of a patient's teeth may cause an overalert dentist to think of the characteristic Hutchinson's tooth, often associated with congenital syphilis. It would be folly to refer the patient immediately for a Wassermann test. If the receptionist had asked the patient's occupation, as is customary in some offices, the dentist might have deduced that the woman, being a beautician, probably injured her teeth when opening bobby pins, or the man held tacks or nails between his teeth while upholstering.

Those who work in an atmosphere of acid fumes incur decalcification of the enamel of their teeth,

and numerous oral lesions are often traceable to the allergens found in the home or factory. Enamel hypoplasia is diagnosed without protracted speculation, if the dentist learns that the patient had rickets as a child. Disfiguring brownish stains on teeth are no mystery, if it is known that the patient's early years were spent in Colorado Springs or any other place where the fluorine content of the drinking water is high.

A lesion on the face of a blue-eyed Scandinavian should be suspected of being a malignancy. It is sometimes amusing when a dentist notices a patient's asymmetrical face and asks if there is a history of a fall down a flight of stairs at an early age. The patient then recalls the long-forgotten incident, and wonders how the dentist knew it. The diagnosis is explained by the injury to the condyle which, being the growth center of the mandible, stopped developing temporarily while the other side continued to grow normally. When the injured condyle recovered, it continued its growth pattern, but it always remained a little behind the other one, giving the mandible its permanent shortness on the one side. The effect can be seen when the patient slowly opens his mouth wide; the mandible deviates toward the short side.

When an acute necrotic gingivitis, also known as Vincent's infection, is presented, the dentist does not have to hesitate about asking whether the patient has been "hitting the high spots," over-indulging in food, drink, smoking, and other indiscretions. By the same token it is advisable to insist on light, nourishing meals and plenty of rest and quiet as part of the treatment.

The diagnosis of Paget's disease, suspected from the "cotton wool" appearance of the maxillary bone in the roentgenogram, may be further substantiated if the patient replies in the affirmative to the question, "Have you had to get a larger size each time you have bought a new hat?" Acromegaly, unknown to the patient, has been discovered by the dentist who observed that the patient wears especially large shoes after he noticed an unusual number of hypercementosed roots in the intra-oral roentgenograms.

Ask Relevant Questions

The questioning must always be *planned with a purpose* so that the deduction from the answer will lead to a diagnosis, much in the same way that Sherlock Holmes followed his clues. It was no accident that the greatest detective in fiction was born in the mind of Conan Doyle, a physician as well as a writer. His prototype for the character was his teacher, Doctor Joseph Bell of Edinburgh University, one of the best medical diagnosticians of his day. When a medical confrere remarked how similar his technique was to that of Sherlock Holmes, Bell drew himself up to his maximum height and said,

"Sir, I *am* Sherlock Holmes!"

Occasionally, questions which lead to implications in dentistry border on the delicate. A woman complained that a postextraction wound would not heal. A biopsy of the bone revealed a squamous cell carcinoma, which implied that it was of metastatic origin. The patient had been questioned about her health and operations, but had given no pertinent information. The biopsy report was relayed to the husband, who informed the dentist that a cancer of the patient's breast was discovered two years previously and a mastectomy had been performed. When the patient was asked why she did not supply the information when the history was taken, she said she did not think it was of importance to a dentist. When the possibility of a postextraction hemorrhage is suspected, it is necessary to ask a woman patient if there was any postpartum bleeding. Questions about frequent nocturnal urination are in order if a periodontosis leads to a suspicion that the patient may have diabetes; if it is true, no surgery must be attempted without premedication with an antibiotic.

"How can a dentist give a patient so much time?" asks the skeptic. Yes, it does take time at first, but the dentist who believes that the physical and psychologic status of the patient is an important factor in his oral welfare, soon learns the art and science of asking questions in diagnosis without wasting any time. Call it hunch, intuition, or sixth sense—it all means that he has applied himself diligently, and has learned how to "jump to conclusions" without the laborious procedure from premise and through ponderous logical sequences to a summation.

In any case, a few minutes spent in formulating questions, which will lead to a good diagnosis, does not seem to be a bad investment in practice building.

431 *West Oakdale*
Chicago, Illinois

YOUR INCOME TAX RETURN

A GENERAL rule to consider when you are trying to decide whether it would be more advantageous for you to sell or trade in an asset is: sell "loss" property to obtain a deduction, and trade "profit" property to avoid the tax which must be paid on any profit realized from the sale of an asset.—*American Institute of Accountants.*

Doctor Current Makes 18th Century Furniture

BY ZOE K. BROCKMAN*

North Carolina dentist finds hobby that satisfies him and enables him to produce beautiful furniture for friends as well as his own home.

WHEN Doctor A. C. Current leaves his dental offices and enters the woodworking shop on his spacious home grounds on Jackson Road, it is likely that the change of locale is relaxing in more ways than one. At least when, tools in hand, he approaches a stack of his favorite black walnut lumber, the wood does not begin to wince and cringe and ask if it is going to hurt. The wood simply submits itself to a master hand at cabinetmaking, and the first thing you know another handsome piece of furniture has joined many fine companions in the big red brick house.

Doctor Current has always liked to work with tools, and he took up cabinetmaking as a hobby some twenty years ago, utilizing a portion of his basement as a work-

*Women's Editor, *Gastonia,* (North Carolina) *Gazette.* This article is reprinted with the permission of the *Gazette.*

shop. However, the fine dust from the wood had a way of creeping into the house, so he built a neat brick shop at the rear of his residence.

Doctor Current's philosophy as to the basic requirements of a hobby adds up to the conclusions that a given hobby should be something that a person is really ambitious to pursue; that the means of pursuing it should be readily accessible to him; that the pursuit of the chosen hobby be within his financial reach; and that the hobby itself should call for both physical and mental exercise. "As we grow older," Doctor Current offered, "we need to maintain interests and we especially need both mental and physical activity."

Doctor Current's workshop is as convenient, well equipped, and orderly as his dental offices, and he has all the tools necessary for turning out well executed and beautifully finished pieces, many of them reproductions of the best in the furniture of the past.

As he rattled off names of a portion of his equipment for my benefit, it developed that the shop contains a thickness planer, bench saw, jointer, jigsaw, spindle shaper, drill press, a lathe for wood, and hand routers, hand saws, and hand shapers, all electrically powered. Accessory tools are grinders and sharpeners; there is a complete set of hand-carving tools and another of hand tools, such as chisels, bits, hammers, and screw-drivers.

Doctor Current takes special pride in his thickness planer and his home-constructed veneer press. Many people are familiar with the exquisite inlaid card tables with which the dentist has remembered a number of his friends. The veneer press, which he made himself, accommodates a full-sized card table. Some of the woods, which he uses in artistic designs and effective contrasts in these tables, are white mahogany from Central America; amaranth from South America; African rosewood; walnut; Brazilian rosewood; birdseye maple; and satinwood from East India, to name a few.

In his workshop Doctor Current has four or five thousand feet of black walnut lumber, his avowed favorite. "Black walnut is a little stubborn and difficult to work with, but the beauty of the finished product is well worth the extra effort," he believes.

What is considered by most of his friends, and perhaps by himself, as his masterpiece is a credenza which was designed for linens but, because of its extraordinary grace and beauty, is used in the lower hall of his home. The chest is 7 feet high, 4 feet wide, and 20 inches deep, and is constructed of beautifully grained solid walnut and lined with wild cherry. The drawers have solid bottoms and the chest is dustproof. A reproduction of an 18th century piece, the wood for the chest came from an old walnut tree on his

father's farm. Around the top of the chest is carved an exquisite flower and leaf design, chosen from an illustration of famous carvings in one of the books which constitute his working library. Among these are *A Furniture Treasury* by Walter Nutting; *Woodcarving As A Hobby* by Herbert W. Faulkner; a set of manual training books from the furniture department of State College, Raleigh; books from Delta Manufacturing Company, and Walker-Turner Manufacturing Company, and several books on handling woodworking machinery.

Another priceless piece is a corner cupboard beautifully inlaid and with sand-glazed panes. In the breakfast room are furnishings calculated to drive any woman mad with envy—a solid walnut Lazy Susan table with six hand-carved chairs to match, making it a toss-up as to which room is lovelier, the breakfast room or the dining room, with a Colonial buffet with Gothic arched doors.

In the hall is an 18th century lowboy above which is a mirror in a hand-carved frame.

Doctor Current has also made a full set of office furniture, including a kneehole desk and matching chairs—all walnut, of course. He has made three dozen of the card tables which are virtually museum pieces. He opens his shop at graduation time to boys in the senior year interested in learning to work with wood. Here he teaches them to make small objects such as bookbacks from carved wood, bookends, and interesting and unusual bud vases.

As to the time he spends in his shop, Doctor Current says he works in his shop afternoons and nights when the creative urge is upon him and there is nothing of more importance for him to do. "If it were not that my pastor is my neighbor, I might even sneak in a little work in my shop on Sunday," the dentist quipped. And then, seriously, "Next to my family, my church, and my patients, the shop means more to me than anything else. Looking at the lumber I am going to use, I can visualize what is to emerge finally from the rough planks, and my hands fairly itch to be at it. If I had spent the time in my shop that I have spent on a few nerve-wracking crusades," he mused, "I might never have had a heart attack. For, once at the business of creating, all worries cease, all problems disappear, and the tools, the wood, and I, are happy companions in an enterprise which seems worth while to me."

Reception Room Impressions—

and Restorations

BY SYLVIA HIMMELFARB

Is YOUR reception room in a stupor, and would a shot in the arm return it to healthy usefulness? Pardon the mixed metaphor but, seriously, have you really looked at your reception room lately? As the wife of a practicing dentist in a busy city, I see the offices of many dental friends. The patient forms his first indirect impression of your personality when he enters your reception room. Because more patients are becoming decorator minded, they are likely to be curious and observant. Your secretary may be charming, your nurse immaculate, and your hygienist efficient. You are a dentist of high integrity and professional perfection, but that reception room tells its own tale.

While brisk business may often exist in drab and dispirited surroundings, a patient never associ-

Here are a few suggestions for making your reception room cheerful and attractive, thereby giving your patients a better impression of you.

ates a professional reception room with this classification. If your reception room is not cheerful, decoratively attractive, and comfortable, you are missing an excellent opportunity for subtle advertising.

Primarily, since this is an expression of my own observations, I must begin with the pictures on the reception room walls. Too often there is the usual uninspired arrangement of meaningless pictures framed in a far from distinguished manner. If there were just one handsome large print or painting, how much more pleasant for the patient to indulge in contemplation remote from dental worries. In a small office often no other picture is necessary. Sconces, mirrors, hanging book shelves, or the drapery itself, could then add charm to the broad areas of the other walls. You may, with equal effectiveness, correlate the room colors to those contained in the picture, or choose the picture to suit the existent room colors. A beautiful picture frame lends refinement to a room, and helps to provide the quiet elegance a dental reception room should reflect. An investment in custom framing guarantees suitability.

Excellent and inexpensive reproductions of the famous paintings in the National Gallery of Art in Washington, DC, are available in most shops dealing with pictures, or the gallery itself will sell and mail them to you. These are especially distinctive, and the selection boasts examples of every period in art, thereby catering to all tastes.

To communicate a sense of repose and warmth in a large office, plan a secondary group of pictures in either balanced or asymmetrical arrangement. Thus, too, the room gains a well designed unit of decoration. The subjects may all be alike or all be different, but they should impart a wall of interest and not one of ineffectual spottiness.

Though this has been said before, it bears emphatic repeating. Do not take old discarded furniture from your home, and consider you are way ahead economically by plunking it down in your husband's dental office. No patient will ever be convinced by this display that you could not afford better. He will just deride your thriftiness, and feel you are anxious to take his money, but are reluctant to spend any of yours to add to his comfort. In addition, he may soon question the sterile technique existing in the adjacent operating room if things look too shabby and unsanitary in the reception room.

Conversely, when a patient walks into a reception room with a well-planned decor, he is flattered. He shares your obvious

pride in your possessions, and respects your desire to appeal to his artistic eye.

Make periodic checks of your reception room furniture. Permit no furniture in your office to proclaim to all incoming patients how badly it suffers from an advanced case of spinal curvature. Keep all the furnishings in good repair, and have the furniture reupholstered when necessary. As new furniture is needed, buy only that which is suitable for your room; small scale pieces of furniture for small rooms and larger pieces, though not necessarily exaggerated masculine ones, for the more spacious rooms. Whether you buy one chair or a single extra lamp, furniture and department stores offer excellent free decorating services. Professional advice of this kind usually adds a magic flair and an inimitable sparkle to the room.

The use of leather upholstery only in offices, is no longer essential. There are many new fabrics, which are extremely beautiful and are constituted for complete durability.

Display Your Hobby

If your hobby is painting, collecting, or the like, bring it to your office for permanent display, locked in a glass case if you are in the least apprehensive. Your patients will think of you as a man of the world. As you may suspect, every patient who leaves your office repeats to his friends or relatives everything that was said there. The patient wants his dentist to be personable and interesting. Catering to all the psychologic needs of a patient is too time consuming, naturally. However, dentist-patient rapport is promoted when your patient reveals his enthusiasm for one of your interests, apart from dentistry. The reception room achieves individuality and distinction through your hobby display, and its conversation provoking features provide the patient with a visual reminder of you.

A word about lamps and lighting fixtures. Have lamps without frills, and avoid giant type lamps for your office. Eliminate small, inconsequential fixtures that throw dim and useless light far from the reading area. Elementary as this sounds, it is a too common fault. Have enough lamps in the room and have them well-sized for smart appearance, and well-placed for illumination.

Drapery in an office softens and mellows the room, adds decorative quality, and imparts a pleasant homelike atmosphere.

A rug or carpet unifies all the furniture within the room, just as a beautiful frame enhances a painting, and has the added advantages of providing a quiet, noncommercial atmosphere. Consider this type of floor covering where possible, rather than the various tile coverings which, while most useful and even beautiful, do not in the last analysis give the room a finished

look or a wholly professional appearance.

In bad weather a handsome china, brass, or even utilitarian umbrella stand will protect the rug.

Magazines contained in wicker baskets or wooden office trays are a neat and immaculate touch.

By all means provide large ash trays, preferably brass or clear glass. Undecorated white china ash trays are always good. Colored china ash trays, though small in the general scheme of the room, often tend to clash with the other colors of the room.

Green living plants are most desirable. In a large office they are exceedingly decorative when grouped together on a particularly interesting stand or table. The room gains importance when plants or any other accessories are made an integral part of the decorating scheme, and not added as afterthoughts. In a small room, plants may be placed artfully in various ways, but keep in mind the overall effect on nearby related objects.

Accessories, generally, should be large and limited; too few, rather than too many.

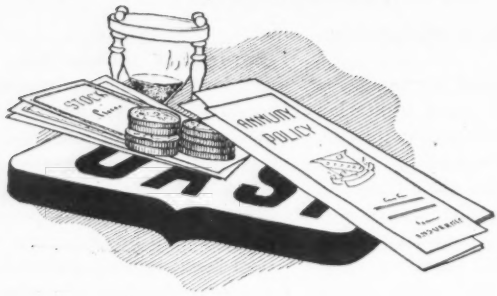
Whether you decide to use all or none of the foregoing suggestions, have your office painted or wallpapered before it becomes drab or faded. Choose colors that really are colors. Forget apartment-house cream, pale grey, or bedroom tints. Do not be afraid of color. Patients love colors, even intensely dark ones, as long as they are not garnish.

Far-fetched though this may seem, for psychologic purposes it is best to avoid deep pinks or any other suggestion of red. You may never learn that the reason a patient stopped coming to you was because your reception room reminded him of blood.

Not long ago my husband had his office repainted, choosing the color as usual from a tiny swatch on the painter's sample sheet, and relying completely upon the painter's long experience. The finished result revealed that the painter was badly nearsighted, for he had used a color three or four hues deeper than the one selected. It was dark green, and in quite a small room too. Since much office time had been lost because of this refurbishing, my husband decided to let it remain that way temporarily. With virtually no exception, every patient who came in was delighted with the color.

It is natural to become accustomed to the objects in your office, and perhaps no changes seem indicated at first glance. When time permits, an objective analysis of your reception room may reveal to you certain obvious areas for improvement. Do avail yourself of the excellent decorating services in your town. Your patients' delight with your revitalized room will more than repay you for your efforts.

1620 *Missouri Avenue, NW*
Washington, DC



Social Security and Its Effect On Your Financial Planning

BY JOHN J. McDONAGH

YOUR COVERAGE under Social Security is compulsory. Dentists were brought under Social Security August first of last year when President Eisenhower signed H.R. 7225. This, of course, will make vast changes in your entire financial program. For example, dependents of a deceased dentist when covered under Social Security might conceivably receive payments totaling more than $40,000 of benefits. On the other hand, at retirement, Social Security could conceivably mean as much as $30,000 to you.

You will be required to pay the Social Security tax when reporting your earnings for 1956, and each year thereafter. The tax for 1956 will be $126; the tax for 1957 will be $141.75, and there are increases scheduled thereafter. (You are not taxed on earnings over $4200 under the present Social Security Law.)

Obviously you should be aware of your benefits under the Social Security Act, and take whatever steps are necessary to arrange your entire financial plans for the future so that you and your family will derive the maximum benefit therefrom.

I believe the best way to apprise you of the impact of the Social Security Act on you would be to take an illustration of a typical dentist from my files and show you his situation both before coverage under Social Security and after, and finally to explain what changes and

Study your future income requirements for retirement, and plan your insurance in coordination with Social Security.

adjustments in his plans were necessary in order to take maximum advantage of the Act. You may then better evaluate your own plans in the area where they parallel the illustration. The names have been changed so as not to divulge anything of a confidential nature.

Doctor Louis Jay is now 40 years old; his wife Audrey is 39 at nearest birthday, and they have three children: William, age 12, Jean, age 9, and Jeff, age 4. Doctor Jay is a veteran of World War II and came out of the service with little cash or other assets. His last year's adjusted gross income was $16,500. Doctor Jay has accumulated the assets shown in the accompanying chart.

Doctor Jay's own ideas regarding his family's needs are as follows:

At retirement by age 65, at least $450 monthly. In the event of premature death, Doctor Jay estimates that $5000 will be consumed for last expenses, and it is his wish that $3000 be left as a readjustment and emergency fund. His wife, Audrey, would definitely want to remain in their home at least until such time as all their children are past college age. It is, therefore, Doctor Jay's wish that the mortgage be paid in the event of his death, and also that sufficient funds be provided to educate his children. These last two items represent $14,000 and $21,000, respectively.

In order for his widow to be able to raise her children and provide all their wants, Doctor Jay feels that she would need an income of at least $500 a month, even if the mortgage was paid. Although Doctor Jay would prefer that the $500 monthly be paid to his widow for the rest of her life, he felt that after all the children are educated she alone should need but $300 a month.

In analyzing the holdings of Doctor Jay, it is apparent that the life insurance purchases have not been pointed in any one direction. We find one contract maturing as an endowment at age 60, another paid up at 65, another 20-payment life, another whole life, and still another, a term contract. No thought was given to coordinating other assets into one cohesive plan for his family's welfare.

More Insurance Needed

However, as Doctor Jay explained to me, the purchases of insurance were made almost half-heartedly with the knowledge that it was utterly impossible for him to accumulate an amount of insurance sufficient to provide for all the wants of his family according to his own estimates. This feeling on the part of Doctor Jay was con-

firmed when working out the program. If we were guided by the needs listed here, and if Doctor Jay did not have the benefit of Social Security coverage coming up for his family at his death, the widow would have been able to pay only the last expenses and mortgage, and to hold in reserve sufficient funds for the education of the three children, plus a $3000 emergency fund. The balance of the assets in Doctor Jay's estate would have provided an income of $500 monthly, but only for eight years, at which time the elder son would still be in college; Jean would be just about starting college, and Jeff would be just age 12.

With the passage of the Social Security Act, Doctor Jay will be currently insured as of April of next year, and since his self-employed earnings are far in excess of the $4200, his survivors would be entitled to the maximum benefits under the Act in the event of his death after that time, as follows:

Social Security would make a lump sum payment of $255 toward final expenses. Then the widow would be entitled to receive $200 a month until such time as Jean is age 18, and $162 for five years thereafter until Jeff is 18, and then starting at age 62 the widow would receive $81 a month for life. If Doctor Jay lives to retire at 65, he will receive $108 a month from Social Security and an additional $54 per month when Audrey reaches 65 (or he can take slightly less at her age 64).

Financial Picture of Doctor Louis Jay— A Typical Dentist

Liquid Cash		$ 4,000
Common Stock (approximate market value)		15,000
Home Valued at	$26,000	
Mortgage	13,671	
Equity (approximate)		12,000
Insurance:		
National Service Life Insurance		
Endowment at 60		10,000
Paid up at 65		10,000
20 payment life		10,000
Whole life (present value)		
with family income		19,000
Five year term		5,000
Group		10,000

Prior to Social Security, Doctor Jay would have had to purchase $85,000 more of insurance in order to fill the minimum requirements for his family needs and for his own retirement. With the inclusion of Social Security in his program, Doctor Jay now finds himself short of his goal by only $39,000. Such is the impact of Social Security in this case. In order to coordinate all his assets and to place the completion of his program within his grasp, the following recommendation was made and acted upon.

The National Service Life Insurance policy is most important in its annuity options to the widow upon Doctor Jay's death, and after considering the advantages of this point, it was Doctor Jay's decision that the policy be so used. The endowment-at-60 plan was not in keeping with this end. Therefore, the first change made was to convert this contract to a 30-payment life policy (still with the government). This had the effect of reducing the annual premiums required and refunding to Doctor Jay a substantial amount of cash.

The second step consisted of a similar change in the limited payment policies. The policy that was to be paid up at 65 and the 20-payment life policy were both changed to whole life contracts, since it was found that the reduced paid-up insurance values at Doctor Jay's age 65 would be adequate to complete his program should he live to that time. In the meantime, the additional protection was necessary for his family.

These changes, likewise, had the effect of reducing his current outlay in premiums considerably, and in refunding to Doctor Jay the difference in reserves in cash.

Next, Doctor Jay applied for $39,000 of additional coverage on the whole life basis, and although the premium was $1028 a year, Doctor Jay found that the reduction in premium from the changes listed here and the application of annual dividends brought his net outlay down to only $600. Prior to this, dividends were being accumulated for no specific purpose and to no advantage, and the cash Doctor Jay received because of his selection of other contracts was sufficient to pay this $600 extra for the next four years. In addition, his retirement program now provides $465 of monthly income at age 65.

In summary, we must agree that Doctor Jay's situation seemed hopeless prior to the coverage under Social Security. With judicious application of Doctor Jay's other assets, the entire program has been brought within striking distance. Inasmuch as each person is unique, and his ambitions and goals are different, we do not recommend that the case cited here be taken as a pattern in any sense. It is necessary that everyone set his individual requirements and have his assets balance against those, because what might be perfectly proper in one case might prove un-

desirable in another. The only recommendation we can make is that each dentist should seek out the counsel of a competent, experienced, licensed agent to review his insurance program annually in the light of his own aims and ambitions, and to coordinate insurance with his other assets to realize the maximum benefit therefrom. Such counsel is given gratis without any obligation on the part of the dentist. The agents who do this kind of work regard the time as an investment in good will for any possible future business.

161 *William Street*
New York 38

STUDY OF FLUORIDATION BY AMERICAN MEDICAL ASSOCIATION

AT THE Seattle meeting of the American Medical Association (November 27 to 30, 1956) the House of Delegates directed the Councils on Pharmacy and Chemistry and on Foods and Nutrition to conduct a joint study of all presently available information concerning the fluoridation of public water supplies and to present a documented report of findings and recommendation at the December 1957 meeting.—*The Journal of the American Medical Association.*

SELF-CRITICISM

SELF-CRITICISM is far more important than criticism of others, for, although we may learn by their mistakes, to criticize them directly or obliquely in the presence of colleagues or patients is surely the one unforgivable sin.—*British Medical Journal.*

THE COVER

THIS MONTH'S cover photograph of a dogwood tree, estimated to be 100 years old in the yard of Charles H. Walthour, Atlanta, honors The Thomas P. Hinman Mid-Winter Clinic, which is holding its annual meeting March 17 to 20 in the Municipal Auditorium, Atlanta, under the auspices of the Fifth District Dental Society. General Chairman of this important meeting is Captain Everett K. Patton, USN (Ret), Box 136, Ben Hill Station, Atlanta, Georgia.

WHEN YOU CHANGE YOUR ADDRESS

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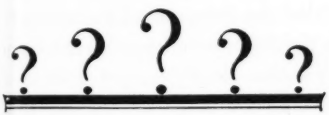


BY ROLLAND C. BILLETER, DDS

CXLIX

1. Addition of relief areas (a) increase, (b) decrease, retention of maxillary denture bases.

2. True or false? The development and growth of the alveolar process depends upon the development and eruption of the teeth.

3. How do you prevent "shrink-spot" porosity when a bulky section of casting is separated from the sprue by a thinner section?

4. About (a) 5-10, (b) 10-20, (c) 30-40, per cent of untreated lesions of oral leukoplakia will undergo malignant degeneration.

5. What is asphyxia?

6. Upon standing, the pH of a freshly prepared solution of procaine hydrochloride (a) rises, (b) drops.

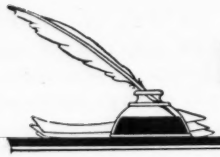
7. Is it wise to use heat sterilization for diamond instruments?

8. Which of the following types of chisels is most desirable? (a) hand mallet and chisel, (b) engine-driven surgical mallet, (c) hand pressure chisel.

9. True or false? Any inclination of the long axis of the teeth results in a difference in the levels of the mesial and distal cementoenamel junctions and produces oblique alveolar crests.

10. With resin cements, do different consistencies of mix vary the hardening time appreciably?

FOR CORRECT ANSWERS SEE PAGE 80



EDITORIAL COMMENT

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." *John Milton*

THE FAMILY DENTIST–BACKBONE OF DENTAL PRACTICE

A BRITISH physician[1] addressing a group of medical students on the subject of general practice told them that the emotions of patients are not an illusion: "You can learn your psychology and psychiatry from the professors or from the poets, the novelists, the Bible, and your own experience, or you may mix them all; but you must not suppose that Psyche is an illusion, an invention of psychologists. She has a finger—sometimes a fist—in every medical pie."

Every dentist knows that each patient is unique. No two dental patients or problems are exactly the same. No two require the exact same treatment. People share a general kind of anxiety toward dental treatment. It is not one of life's more pleasurable experiences. Added to the general apprehension are specific dislikes. One patient dislikes the sound of the dental drill. Another fears that he may choke when his mouth is filled with cotton rolls or impression material. Another trembles before the injection needle. Some patients are mobilized in defense against every form of treatment procedure. There are a few dear souls who are quite indifferent to the whole affair.

General practitioners have less public recognition and a lower income than is accorded specialists. The blight and the plight of the general practitioner appears early in the medical career. While still students many young medical men have already set their sights on a specialty before they know much about the body as a whole. The same tendency is appearing in dentistry. Dental students are talking about becoming oral

[1]Patten, L. W.: Essence of General Practice, The Lancet **271**:368 (August 25) 1956.

surgeons, orthodontists, or whatnot well in advance of graduation.

Specialization is a desirable motivation. The specialist, however, should evolve his skills from a framework of experience in general practice. The only way to understand the problems of any patient is to see the person as a total entity living in a complicated and stressful environmental field. The orthodontist who has never treated a diseased pulp or the oral surgeon who never constructed a denture, lack a kind of essential experience that restricts understanding of clinical issues. There is even a form of boastful pride: "That's out of my field. I don't know anything about that." This is not an expression of modesty, it is restrictive ignorance.

Unlike the physician who is required to serve an internship that compels him to see something of the whole of medicine, the dentist may become a "specialist" the day that he receives his diploma. In a few states there are laws that require a dentist to show extraordinary skills before he is granted a specialist license. The various Specialty Boards have extremely high standards for acceptance. Despite these standards there is nothing to prohibit any dentist from conferring upon himself the accolade of *specialist*. It is done every day in every part of the country.

There is a movement to put the general medical practitioner back in the position of importance that he deserves. The current president of the American Medical Association is a general practitioner. There are societies of general practitioners. This movement has yet to attract much attention in the dental profession. We still seem to be unduly attracted to the specialist label.

Before any dentist moves into the restricted area of specialized practice, important as it certainly is, he should spend at least three years "doing everything" as a family dentist. Aside from the multitude of dental problems that will confront him, he will gain an understanding of people and their emotions that will enrich him for his later work.

Edward J. Ryan

Dentists in the NEWS

Fort Myers (Florida) News Press: A 3000-acre ranch and farmhouse near Daytona Beach is being offered to some Hungarian refugee family by Doctor Edwin C. Lunsford "for as long as they need it, 10 years if they wish." With the cooperation of B. A. McCray, Mayor of New Smyrna Beach, the family will be given free electricity for a year, and will be guaranteed employment if they prefer to work at a job instead of farm the ranchland.

"If this offer has to have a reason," Doctor Lunsford explained, "let's say it goes back twenty-six years. I was there (in Hungary as a University of Budapest student) and I needed money. I went into the bank of Budapest and they cashed a check for me. Just like that! I've learned a lot more about that country since."

Boston (Massachusetts) Herald: Doctor Harry S. Parsons, a Winchester dentist, has established a $2500 scholarship fund at Bowdoin College in memory of the late George Winfield Parsons, his brother, and former Winthrop and Medford, Massachusetts, school teacher. The fund will be used to aid "any student from Brunswick who needs a little financial help," Doctor Coles said.

DesMoines (Iowa) Tribune: Abraham Lincoln's place as "the greatest President" was not even closely challenged in a personal survey conducted by Doctor Cornelius B. Welle of Newton. Doctor Welle, who has modeled plastic wood figurines of all 33 presidents of the United States as a hobby, became interested in the public evaluation of those leaders as he displayed the figurines for clubs and organizations. He distributed a questionnaire to viewers on which he asked, "In your estimation, name the Presidents of the United States in their order of greatness." Lincoln received 110 votes for first place, Washington 87, Franklin D. Roosevelt 16, and Eisenhower 9.

Butler (Pennsylvania) Eagle: Doctor Albert R. Pechan of Ford City has been re-elected as State Senator for the 41st legislative district (Butler and Armstrong Counties) for a third term. Doctor Pechan had no trouble in winning his third term to the State Senate. He carried both Armstrong and Butler counties by comfortable margins to defeat his Butler County opponent, Harry F. Pepper, local florist.

Rochester (New York) Democrat and Chronicle: By allowing cavities to be drilled in his own teeth, Doctor Henry D. Rohrer, Jr, has learned the cause of severe toothaches that sometimes grip airmen at high altitudes. Doctor Rohrer, who recently completed a two-year tour of duty in the Air Force, was cited for his discovery of the cause of the toothaches, a condition known as aerodontalgia, while serving at Mitchel Air Force Base Dental Clinic on Long Island.

He theorized the pain was caused by a gas produced by caries in a cavity inside the tooth. This gas has no path of escape at high altitudes, and pressures force it inside the tooth, resulting in severe pain.

To test his theory, Doctor Rohrer submitted himself as a "guinea pig." He instructed another Air Force dentist to drill cavities in several of his teeth, and

to place restorations in them, but deliberately leave small voids, or pockets. This was done to simulate caries and faulty restorations. He then entered a high altitude chamber that created pressure conditions similar to those at 15,000 feet and above. The result: Stinging pain in the teeth having air pockets.

Omaha (Nebraska) World Herald: About one hundred dentists, including visitors from the East and West coasts, recently attended the two-day semi-annual clinic of the Woodbury Study Club. Shortly after the clinic opened at Creighton University, the delegates donned professional attire, and began giving dental treatment to 60 Boys Town residents.

The dentists meet twice a year to perfect techniques in the use of gold foil restorations. Results of their work are shown in the mouths of the Boys Town patients.

During the clinic three of the cofounders of the club were honored at a dinner. They are Doctors Edward H. Bruening, P. T. Barber, and Percy J. Hunter.

Chicago (Illinois) American: At 90 years of age, Chicago's Doctor Vida Annette Latham is still practicing dentistry and medicine, doing research, and pursuing geological study and composing music for relaxation. It is easy to understand why she has just been chosen the Medical Woman of the Year by the American Medical Women's Association (Branch No.II), even if you do not know about her professional and scientific distinctions. One professional summation of her career reads: "Doctor Vida A. Latham has not been excelled by any man . . . and her election to presidency of the Section of Stomatology of the American Medical Association was merited appreciation of her scientific record."

New York (New York) Times: When Doctor James H. Scriber of Framingham, Massachusetts, arrived at Little America, Antarctica, recently he was somewhat unnerved by the stampede of "welcomers" that rushed him as he prepared to debark from the plane on landing. He was bewildered for a moment until the men leaped into the plane and seized the mail bags at his feet. The bags contained apples; and apart from mail and women friends, nothing has been missed more than fresh fruit by the men at this camp.

Birmingham (Alabama) News: A personable young Brazilian, Doctor Henrietta Poetsch, is studying at the University of Alabama Dental College on a scholarship from the Rotary International Club in her home town of Pelotas, Rio Grande do Sul, Brazil. Not only is she unusual as a woman dentist in the university, but her specialty in the field of children's dentistry is not a usual one. She has been especially delighted with her work here at the Crippled Children's Clinic.

Burlingame (California) Advance-Star: "I still feel 100 per cent," remarked Doctor Edwin R. Waterman recently as he celebrated his 96th birthday. Doctor Waterman began his practice in Burlingame in 1927. But before that he had practiced in San Francisco, Berkeley, and in the Mother Lode country. He has also been boxing coach, ventriloquist, magician, and composer, carrying on all these, except the first, since he retired from dentistry.

Tulsa (Oklahoma) Tribune: One of Mexico's leading dental surgeons, Doctor Miguel Rosani, head of the department of oral surgery, University of Nuevo Leon School of Dentistry at Monterrey, discussed the status of Mexican dentistry at a meeting of the Tulsa County Dental Society. Doctor Rosani stated that Mexico offers an unparalled challenge to young men interested in dentistry. Plans are under way in Mon-

terrey to build a new dental school which would take care of 500 students. All courses are taught by practicing dentists, since there is a acute shortage of dentists. Schooling costs less than $1 per month, and the only requirement for students graduating in Mexico after five years of dental training is that they work 5 months among the poor under Mexico's social service program.

Kansas City (Kansas) Kansan: Doctor Aubrey G. McKinley, who is semi-retired, has made a success of his second career as a salesman. Doctor McKinley recently sold his 100th Chamber of Commerce membership, making a total of $3500 in memberships in less than a year, an achievement unequalled by any other member of the Kansas City organization. Official recognition in the form of a diamond chip set in the corner of his gold permanent membership card will be presented to Doctor McKinley at the Kansas City Kansas Chamber's annual dinner in March.

Columbus (Ohio) Dispatch: Mount Vernon may not have started the atomic age, but an early Mount Vernon dentist pioneered in the atomizer age. Doctor William F. Semple, more famed as the first American to patent chewing gum, invented "the first practical atomizer" in the late 1870's or early '80's. Sale of the atomizers was held up by the fact that Doctor Semple had also invented a medicine to be used in the sprayers, and refused to sell the atomizer without the medicine.

Tucson (Arizona) Citizen: Doctor Foster R. Sims is probably one of the few dentists who puts gold in his patient's mouth and then is paid in gold for his services. For the past 13 years he has practiced his profession in Palmer, a small town in north central Alaska. While Palmer is primarily a farming and dairy center, there are still a few sourdoughs in the hills who come in with a poke of gold dust when they need dental treatment.

Doctor Sims first visited Alaska during World War II, and decided to return after his discharge. A native of Nebraska, he had no fear of cold weather. However, he believes in being prepared for the worst when traveling. Included in his wardrobe for a trip home was a $300 parka made of lynx fur and trimmed in wolverine. "The wolverine around the collar is used because frost will not form on it when you breathe in sub-zero weather," he explained.

Until last year Doctor Sims had the area pretty much to himself, but a dentist from Phoenix moved in, and now the residents of the area do not have to suffer and wait if either one of them is out of town.

Doctor Sims attributes his growing practice to the fact that the Eskimos prefer sweets and soft drinks to food. "Their teeth are getting as bad as ours," he added.

Boston (Massachusetts) Globe: Two thieves working on Doctor Mitchell J. Nore's office safe were quite surprised when the dentist walked in. They dropped their drilling equipment, and jumped out the window into an alley. However, Doctor Nore pursued them, and, with the help of a neighbor and his car, forced their cab to the curb just in time for the patrol wagon to pick them up.

Sioux Falls (South Dakota) Argus Leader: Following a career that took her to Europe and twice to the Orient for the Red Cross and the Armed Services, Marcella Heller decided to begin the study of dentistry at the University of Arkansas. In 1955 she completed her course at Northwestern University Dental School and returned to her home town, Ideal, to become the only practicing woman dentist in South Dakota. Some of her patients come from ranches forty or fifty miles distant. "Despite my

world-wide experiences," she reports, "I am finding this scenic country with the buttes and tree-lined gullies and its unusually interesting people an ideal place to practice dentistry."

Chicago (Illinois) Tribune: The National Dental Association, which represents 1000 Negro dentists throughout the country, has recently elected Doctor Charles M. Thompson as president. The organization, formed in 1913, gives service to both the Negro practitioner and the public. It seeks to increase facilities for training Negro dentists, and helps provide funds for needy but capable Negroes to undertake the study of dentistry. Doctor Thompson, who is a former president of Chicago's Lincoln Dental Society, plans to expand the association's program during his administration beginning in 1958.

Awards for items submitted for this month's DENTISTS IN THE NEWS have been sent to:

Jean Foster, 6912 North Wayne Avenue, Chicago, Illinois
Ross E. Waltzer, DDS, 204 Medical Arts Building, Tulsa 3, Oklahoma
Mrs. E. J. Wuebben, RN, 1508 Capitol, Yankton, South Dakota
Mrs. Manuel Shore, 3927 Oxford, DesMoines, Iowa
Doctor D. D. Canterman, 104 North Main Street, Butler, Pennsylvania
Glover P. Parham, 846 60th Street, Fairfield, Alabama
Mrs. J. A. Murphy, 363 Chili Avenue, Rochester 11, New York
Theseus Standifer, 3033 Emmet Street, Omaha, Nebraska
Theodore Katz, DDS, 2802 Grand Concourse, Bronx 58, New York
Mrs. Helen Griffith, 209 East Lincoln, Tullahoma, Tennessee
Mrs. Mildred Hrzenak, 2113 North 43rd Terrace, Kansas City 4, Kansas
Edward C. Mills, DDS, 220 South Cassady, Columbus 9, Ohio
Mrs. Gladys E. Browne, 33 Pearl Street, North Weymouth 91, Massachusetts
Robert O. Barney, 213 Natalen Avenue, Apartment C, San Antonio 9, Texas
Carolyn R. Evans, 1840 North Wisconsin Street, Racine, Wisconsin
Elsie L. Jenks, 1 Newton Street, Hopedale, Massachusetts
R. Glenn Johnston, 174 Prospect Avenue, Fort Myers, Florida

REFERENDA FOR FLUORIDATION

THERE IS no great interest in oral hygiene. The utilization of dentists fluctuates greatly with aggregate income. It is eminently elastic, indicating a non-critical commodity. Many people do not go to dentists, and of those who do many may be as interested in appearance and status as in health. Although dental caries constitutes a disease problem of some magnitude, there is no large voluntary organization supporting measures, such as fluoridation, to overcome the problem.—C. A. METZNER, *The Bulletin of the American Association of Public Health Dentists.*

DEAR ORAL HYGIENE

Avoiding Bootleg Dentistry

In regard to the article by Charles Fitz-Patrick on bootleg dentistry[1], I believe a system whereby only a licensed dentist could write a prescription for every set of denture teeth leaving the supply houses may correct the situation. This should accompany the dentist's prescription for laboratory service. Of course, I realize there are many points of resistance to such a system, but it is one we might consider at an early date.—T. B. BARTLE, DDS, 606 *South Hill Street, Los Angeles* 14, *California.*

Diet of Bolivian Indians

I have read with a great deal of interest, as I always read everything published in ORAL HYGIENE, the article, AMAZON EXPEDITION HUNTS CLUES FOR DENTAL CARIES, prepared by Doctors Neumann and DiSalvo,[2] of the well-known Columbia University. With the permission of these worthy professors, I wish to add further comment to this article.

I, as a native of a country which is 95 per cent populated and cultivated by the Indian race, have had the opportunity to observe numerous interesting aspects of diet, many of them inexplicable, because of the fact that there does not exist adequate material or time to investigate and explain these simple suppositions.

As the authors of the article have pointed out, our Aymara Indians (people who represent the major population of the Altiplano or high Andes) and the Quechua (people of the Valley of Cochabamba, Sucre, and other places) have a diet, not at all rational, but rather deficient. But the Aymara have dental superiority over the Quechua, and it is this point that I wish to discuss.

Our Aymara, especially those who live on the Altiplano, possess in 99 per cent of the cases completely healthy teeth, lacking in caries. Their diet consists of hard foods.

Carbohydrates and sugars are consumed in minimum proportion. Corroborating the distinguished professors of Columbia University, I would say that the resistance to dental caries is due exclusively to the hardness of the food consumed and to the mechanical hygiene that is produced automatically, for all these foods, and especially the cocoa leaves are fibrous, and the fibers penetrate the interdental spaces, performing a hygienic service.

I also believe that the hereditary factor has some influence, for I have had the occasion to see children of our Indians who had left the country at an early age and gone to the city to work as servants, who changed their diet completely, and yet their teeth remained completely healthy.

Finally, the law that says, "The function makes the organ" is proved once more. Microscopically, I have been able to observe that the density of the enamel of the teeth of the Indian is double that of the city dweller who has a modern diet.

When we occasionally extract a tooth for an Indian, in 90 per cent of the cases we know that it will be extremely difficult, because the roots are always spread

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[1]Fitz-Patrick, Charles: Mum Is Not The Word on Bootleg Dentistry, ORAL HYGIENE, **46**:1373 (November) 1956.

[2]Amazon Expedition Hunts Clues to Dental Caries, ORAL HYGIENE **46**: 839 (July) 1956.

out, of great length, and firmly implanted—all of which constitute serious problems for the dental surgeon.

With reference to the masticatory force, although I have not performed experiments with a dynamometer such as used by the professors of Columbia University, I think that our Indian has a masticatory force superior to the 184 pounds that the professors obtained for the Indians of Peru, for I have seen our Indians raise with their incisor teeth packages weighing 75 pounds, and open with the greatest facility cans of preserves and bottles.

But here is the interesting point, our Indians, Aymaras, or Quechuas, inhabitants of the Yungas or valleys, whose diet is equal to that of the former inhabitants of the Altiplano, and perhaps more complete, for they consume fruits and garden vegetables, have dentition, not in the same condition, but perhaps even in worse condition. How is this to be explained?

I think that the ultraviolet radiations that we know are much more intense at a higher altitude have their influence, because the foods are, in the majority of cases, well exposed to the rays of the sun.—Luis Ml. Zubieta R., Cirujano Dentista, *Casilla* 295, *La Paz Bolivia.*

BE YOUR OWN ECONOMIST

Every dentist will be benefited considerably if an experienced colleague will watch him operate for a certain length of time and point out to him errors in his techniques and procedures that escape him each day and yet are damaging his practice. It is, of course, difficult to obtain this type of advice, unless you are fortunate in being able to exchange such service with another dentist. Therefore, it is important that each dentist set himself up as his own critic, and try to discover his own errors and defects. In permitting a dentist to qualify himself in this sense, dental economics represents a powerful ally of whose aid it is not sensible to deprive yourself. Through self-criticism, we will accomplish what to my way of thinking is the ideal, "that each dentist be his own economist."—Doctor Marcelo Friedenthal, *Economía Dental, Buenos Aires, Argentina.*

ANNUITY FOR SELF-EMPLOYED

Weeks in advance of the convening of the 85th Congress, considerable sentiment had been found among the newly elected members for the principle of the Jenkins-Keogh bills. They are the measures that would allow a deferment of taxes on money paid by the self-employed into annuity plans. The American Bar Association's Committee on Retirement Benefits has sounded out House members and found more than half of them in favor of the principle. Of the 435 Republicans and Democrats in the House, 294 were reported in favor, 120 views were unknown, 18 were noncommittal, and only 3 opposed. Under present plans, a new bill is due to be introduced by Representative Eugene Keogh (Democrat, New York) that will allow for withdrawal of funds from a retirement plan in advance of age 65 upon payment of a small penalty.—*The Journal of the American Medical Association.*

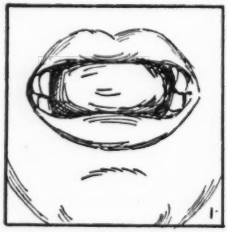
TECHNIQUE of the Month

Originated by W. EARLE CRAIG, DDS

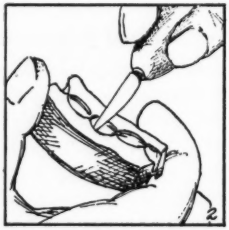
Immediate Technique for Esthetic Temporary Bridge or Crown

By EUGENE FEINSTEIN, DDS

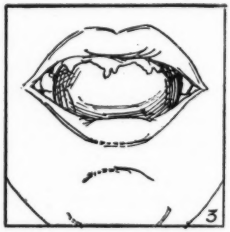
Drawings by Dorothy Sterling



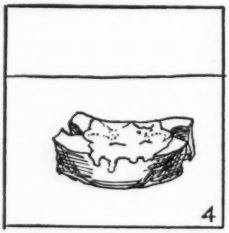
Before preparing the teeth for jacket or veneer crowns, take a simple squash bite in wax. Set this impression aside in cold water. Prepare teeth in usual manner.



Cut tooth-forms into the wax impression between the abutment teeth. Fill impression with self-curing acrylic of the proper shade.



Position acrylic-filled impression in the mouth and have patient bite into occlusion. (Excess acrylic will be expelled in the process.)



When the arcrylic begins to warm and set, remove carefully from the mouth and set aside to cure.

Trim flashing. Adjust occlusion. Polish and cement in place. This temporary bridge maintains proper spacing and occlusion and reproduces the original forms of abutment teeth.

Note to Contributors

We invite dentists to submit material for this page. $10.00 will be paid for each technique used. It is not necessary to make finished drawings—or even sketches—if you explain the procedure clearly, in detail, in your letter. Submit material to:

Technique of the Month,
Oral Hygiene,
1005 Liberty Avenue,
Pittsburgh, Pennsylvania

Q ASK Oral Hygiene A

Please communicate directly with the department Editors, V. Clyde Smedley, DDS, and George R. Warner, MD, DDS, 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply.

Speed of Dental Caries

Q.—The question of the speed of the process of dental caries has been asked me, and I have been unable to make a definite statement. I am aware that it would vary according to a number of factors, such as diet and the structure of the enamel.

Do you have any information upon which you could make a statement as to the shortest time a proximal cavity on a molar could progress from its beginning to pulp involvement?—J. W. W., Georgia.

A.—As you say in your letter there are many, probably too many factors involved, to estimate the speed of dental caries.

I have watched many cases in which the roentgenogram showed beginning caries in the proximal surface of a molar or bicuspid, but which did not seem deep enough to warrant preparing a class II cavity. According to the seeming susceptibility of the patient I have made a new roentgenogram in either six months or a year. I have been surprised in an occasional case at the great depth of the caries in six months, although without pulp involvement. In one case I made bitewings annually for twelve years before beginning caries developed to the point of cavity preparation seeming to be needed in a maxillary first molar. And, while the caries was deeper in this case than it appeared in the roentgenogram, it was not dangerously deep.

However, considering that cavities often, if not usually, prove to be larger when opened than they appear in the roentgenogram, it would seem wise to consider it time o fill a cavity as soon as discovered visually or roentgenographically. —G. R. WARNER

Gagging

Q.—I have constructed immediate dentures for a physician. The upper presents no problem. The lower causes him to gag. When it loosened up I rebased it, and some relief was obtained; but now the gagging is just as annoying. He slept with both dentures, as requested; but now he sleeps without the lower.

This is my first experience with a lower being the cause of gagging. Thank you for any suggestions.—W. F., New York.

A.—It is indeed unusual that this physician's lower denture and not the upper causes gagging. Where the upper denture is the cause of gagging, a usual remedy is producing a firmer postdam to prevent a make and break of contact as the soft palate moves in function. With this lower I would test the fit with disclosing wax, having the patient talk, chew, or

do whatever he does when gagging occurs. The disclosing wax is soft enough to be extruded or displaced by muscle action in function, showing you areas where the movable tissues may be in too heavy or too weak contact with the denture, causing the gagging.

It is possible though that nothing you can do with the denture will prevent this occurrence. In that case it is simply up to the patient to break himself of the habit or impulse of gagging. Many others have done so, and no doubt this man can also.

In my opinion there is no reason to wear either denture at night, if the patient is more comfortable with them out.—V. C. SMEDLEY

Mouth Burn

Q.—Is there some ointment that I may use on the tissues within the oral cavity when a patient has blistered the tissues with an aspirin tablet, or they have been injured with hot modeling compound.—F. S. W., Maine.

A.—I believe a solution of baking soda is more efficacious than any ointment that I know for application to a burn in the mouth. —V. C. SMEDLEY

Inflamed Lesion

Q.—I have recently given a patient, a 43-year-old woman, a mandibular conductive injection. Within three hours the patient developed, on her lower lip, on the same side, a large blister with inflamed margin. The lip was not bitten nor affected by any caustic substance. I have heard that an ulcerous condition of this sort can result from the injection. If so, can you give me information concerning the etiology and treatment thereof? Could my technique or the type of anesthetic be responsible.—G.G.R., New York.

A.—It seems to me that if the inflamed blister you speak of was caused by the injection it would occur at the site of injection, and not on the patient's lip.

It is my opinion that both you and your patient are mistaken in your opinion that she did not bite her lip while it was anesthetized.—V. C. SMEDLEY

Loose Dentures

Q.—In February 1955 I made dentures for a woman patient about 45 years of age. She returned for a reline in March 1956. Lately we have noticed that the dentures are loose.

She has been losing weight, and most of the time her mouth is dry. Could this condition be caused by diet and medication?—G. J. P., California.

A.—The loss of weight of your denture patient could well account for the loosening of the dentures. But, as part of the medication which she is under is to improve her appetite, her weight may increase bringing improvement in the fit of the dentures.

I note from the accompanying memorandum that she is also under medication for chronic constipation and for gall bladder trouble, and this part of her treatment may have something to do with her dry mouth. However, this condition may improve as her general health improves.—G. R. WARNER

Full Mouth X-Rays

Q.—I have a patient, 18 years of age,

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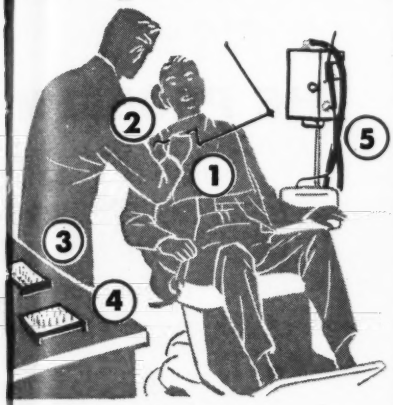

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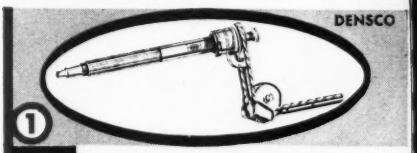

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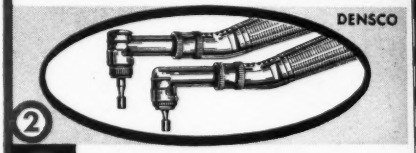

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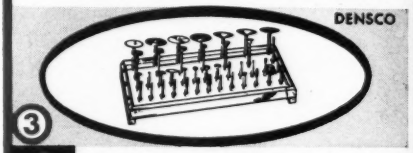

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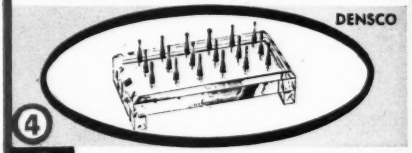

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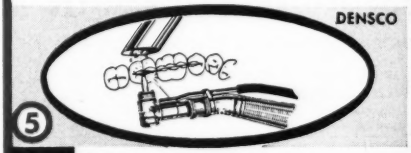

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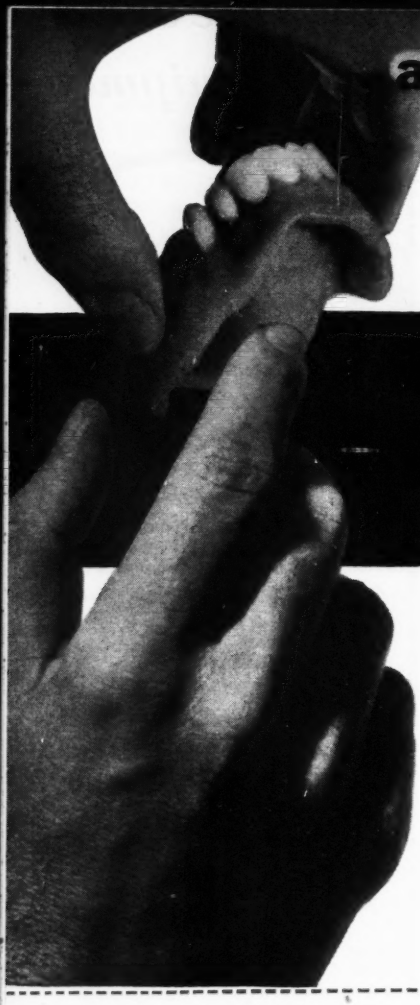

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WERNET DENTAL LORE

FEBRUARY, 1957

The evolution of "dental nursing assistant" to "dental hygienist" began in this country about 75 years ago. It was Dr. M. L. Rhein who first suggested in 1880 that women be trained to render prophylactic dental treatment; and Dr. Albert C. Fones of Bridgeport, Conn., who first acted on this suggestion, beginning with his own office assistant.

• • •

While 19th century dental practice was slow in many ways in taking advantage of contemporary scientific advances, it was far in the vanguard in its use of the Roentgen ray (X-ray). Only two weeks after the announcement of their discovery in 1895, X-rays were used in dental procedures by Otto Walkhoff of Munich. In this country they were first employed one year later (1896) by C. Edmund Kells.

• • •

The great humanist Erasmus of Rotterdam did not overlook dental considerations in his book of manners "De civilitate morum", first published in 1539, which ran through 30 editions in 6 years. In it he criticized the common habit of picking the teeth at table with a knife, a fingernail, or a napkin —recommending instead a small mastic stick, a quill, or a chicken bone.

• • •

One of the most precious relics of Buddhism — the sacred tooth of the great religious teacher Gautama Buddha—has been retained in India only with the greatest of difficulty. Seized and destroyed by the Portuguese in the 15th century, it was replaced by the Khan with one of ivory twenty times oversize, housed in a palace in the remote hills. This in turn was stolen during wars with the Portuguese, the Dutch and the British. Since 1915 the Indians have found the means of retaining that sacred tooth safely and securely . . . a symbol (we may imagine) of the enhanced retention which India today affords denture wearers, because their country provides Gum karaya, basic ingredient of Wernet's Denture Powder.

whose parents request full mouth roentgenograms every four months. Do you feel that this procedure could be detrimental in any way.—G. D. M., Michigan.

A.—It is unnecessary to make a complete periapical x-ray examination for anyone every four months. And, moreover, so much x-radiation, especially for a young person, could be unsafe. In cases of high susceptibility to caries it is wise to make bitewing exposures of the posterior teeth at six month intervals.—G. R. WARNER

Loss of Sensation

Q.—Over a year ago I removed a lower right second molar. The roentgenogram showed a slight curvature of the roots and pulp exposure. The tooth was removed under mandibular anesthesia with minimum difficulty.

Recovery was uneventful. However, about ten days after, the patient complained of lack of sensation in an area about one-half inch or more wide, from the vermillion border to the inferior border of the mandible, both externally and internally, in the region of the mental foramen.

Lateral jaw plates and periapical films taken and examined at the local hospital were negative.

We assured the patient that since the x-ray findings were negative, and the site of extraction healed uneventfully, time would eventually restore the normal sensation. What else could I do?—C. F. B., Wisconsin.

A.—I agree with you that there is probably nothing that you can do in this case, but assure the patient as you have done, that in numerous cases on record the normal sensation eventually returns to such an affected area. Sometimes it is two or three years, but usually not that long.—V. C. SMEDLEY

Sensitive Areas

Q.—What is the best drug to put on sensitive teeth that have been cut down to allow for a rest or a clasp?—E. A. K., Washington.

A.—If the sensitive area in question is not where discoloration would be objectionable, silver nitrate could be satisfactorily used to reduce the sensitiveness. The plain or ammoniated silver nitrate could be used and reduced with eugenol or formaldehyde solution. Formaldehyde solution rubbed on the area with a wedge and orangewood stick would be an effective remedy. But care should be taken to prevent any of the formaldehyde touching the soft tissue.—G. R. WARNER

Leukoplakia

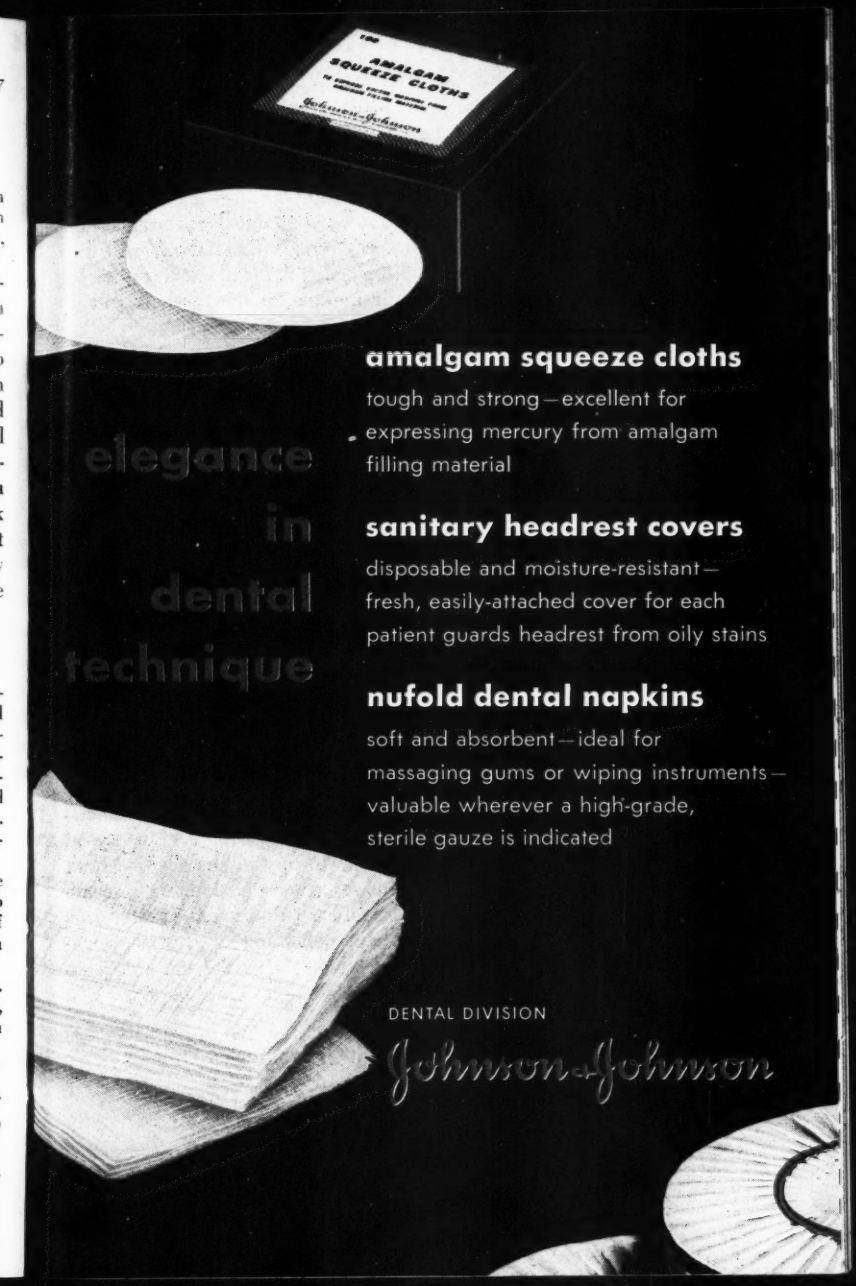
Q.—In December 1952 I made an immediate lower denture for a 50-year-old woman. She returned recently after several years with an area typical of leukoplakia about the size of a dime, but irregular. This area in the lower second bicuspid region extends from 2-3 mm. below the crest of the ridge into the reflecting tissue lingually.

I immediately polished this area on the denture, and removed what appeared to be a slight over-extention; rounding off the area, and polishing. Do you think a reline would help?

Please advise the proper procedure. She has been under a physician's care, but no treatment of this area has been undertaken.—G. J. P., California.

A.—Does this woman smoke? Heavy smokers are likely to develop leukoplakia. If so, advise her to stop all use of tobacco.

Certainly this area should be re-



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lieved of any abrading or irritating denture pressure. I would test the denture fit with disclosing wax, and determine from this test whether this area can be properly relieved by grinding and polishing, or whether a rebase is indicated.—V. C. SMEDLEY

Low Back Pains

Q.—A 37-year-old man has been referred to me for roentgenograms by a physician after treatment for low back pains. Do you think the impacted cuspid could be the cause of his disorder?—R. H. B., New Jersey.

A.—The impacted cuspid in question is on the left side of the maxilla, and as there is a radiolucent area in the bone next to its crown, perhaps a cystic area, it is possible if not probable that this is a menace to the patient's health. Indeed, one authority[1] feels that such a tooth is a source of infection and neurologic trouble. — G. R. WARNER

"Squeaky" Restorations

Q.—Recently, several patients in my practice have complained of "squeaking fillings." I always polish my restorations, so the trouble is not on the occlusal surfaces. The trouble usually arises when a two-surface alloy is placed adjacent to an old alloy. The "squeak" comes at the contact area. I am careful to disk the old restoration that will be contacted by the new with a sandpaper disk, and try to pack with pressure to get firm contact.

This is a minor problem really, and it does not occur every day, but I thought possibly you might have a suggestion or "trick of the trade" to remedy the situation.—I. C. H., South Carolina.

A.—For your "squeaky fillings" you might try working a little vaseline or other lubricant between the teeth. Or if the patient will just disregard it for a few days, weeks, or months, at the most, it will no doubt correct itself.

This condition seems only to occur with new amalgam restorations, and it is said to be due to the tin content of the amalgam. Polishing the restorations usually stops the squeaking.—V. C. SMEDLEY

Chrome Workers

Q.—Some time ago I wrote to you on the question of chrome workers and the hazards of their work. I have looked into this matter quite extensively, and it seems to me there is a great similarity between the oral symptoms of the chrome worker and pyorrhea. Could you please give me any information you may have on the differences in these two oral conditions.—S. L., New Jersey.

A.—Not having had chrome workers as patients, and not knowing the effect in the oral cavity on those working in chrome, I cannot answer your question. As I recall, I could not find much, if anything, about poisoning of chrome workers when you wrote me before.—G. R. WARNER

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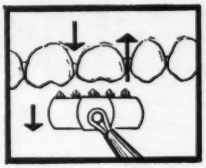
[1]Lucas, C. D.: Physiology and Pathologic Status of Impacted and Unerupted Teeth, JADA (February) 1935.

CLEAN-BE-TWEEN



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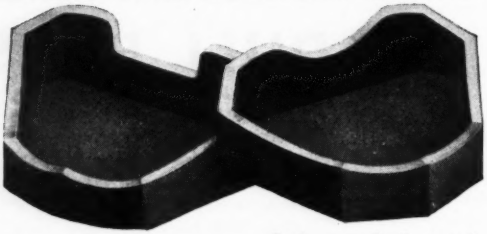

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Good boy, that Jimmy. Sits up there and tells *me* jokes! Maybe he senses *my* feelings about his endless cavities! What can I do to help that boy between appointments? Hope that this time he uses that new brush the way I told him to! And maybe now he'll start eating apples without taffy on them! Glad I started him on Crest. There's something he doesn't have to *learn how* to use. I'll feel like celebrating if it proves to be the dentifrice I've been hoping for—and reports indicate it is! I'll have to put a number of patients on Crest. Should start seeing a difference about . . . when was Jimmy's next appointment? Oh, yes—August 6th.

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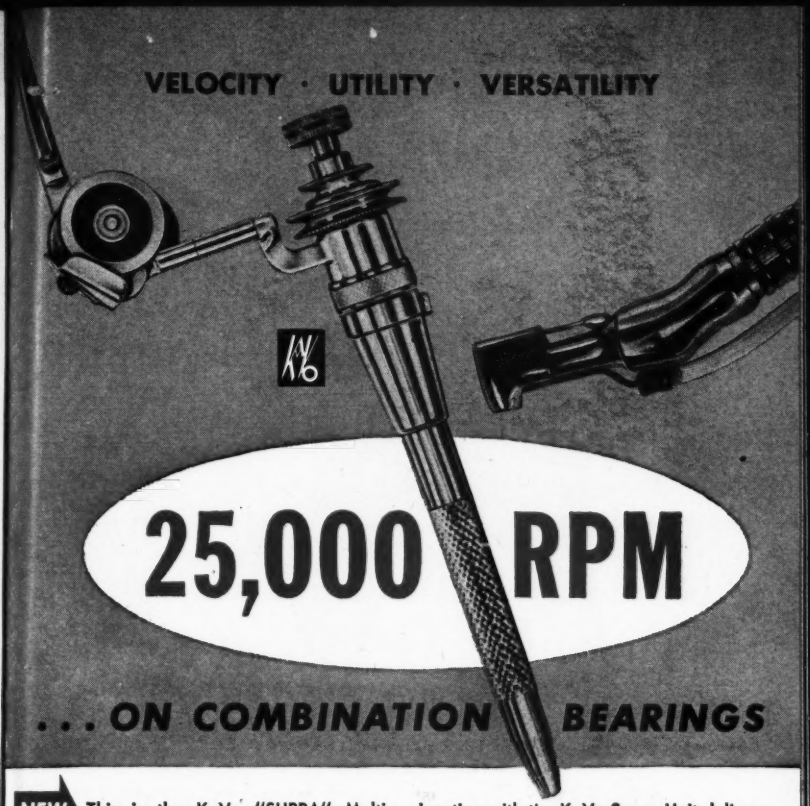

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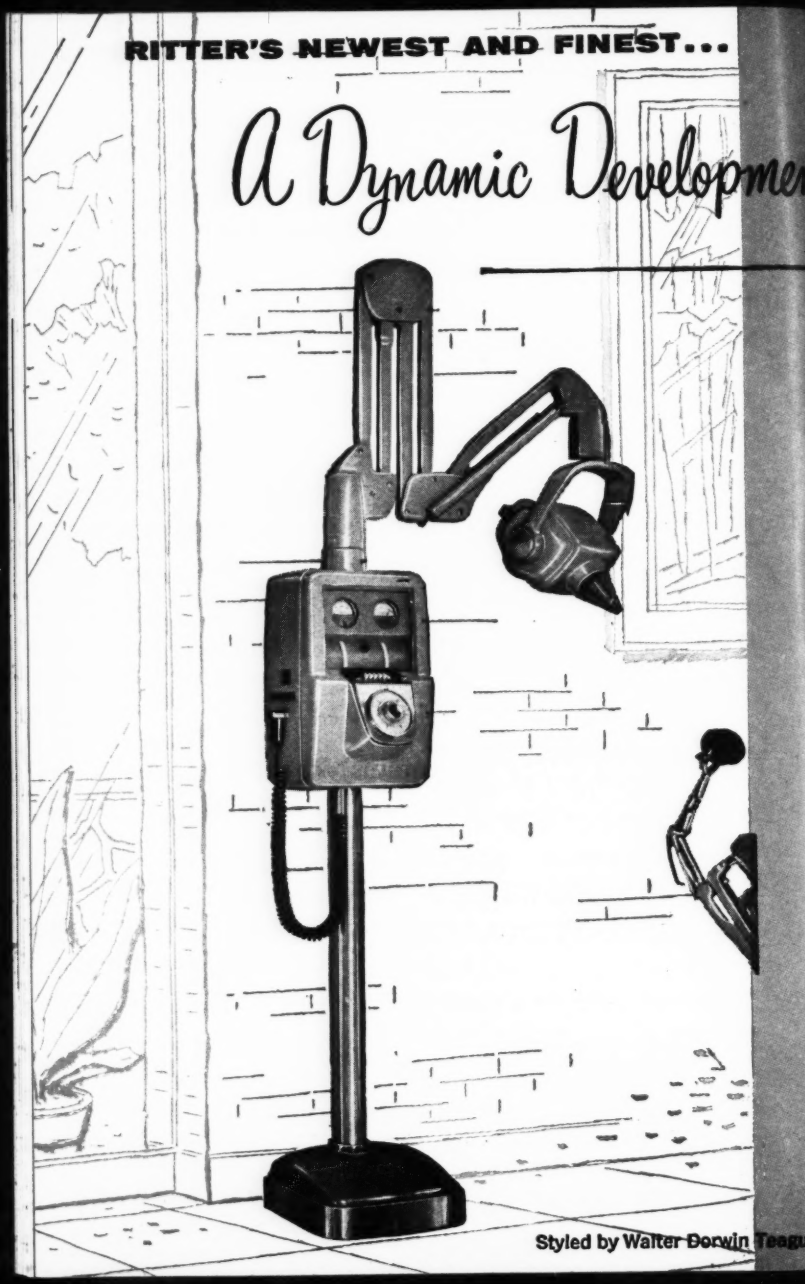
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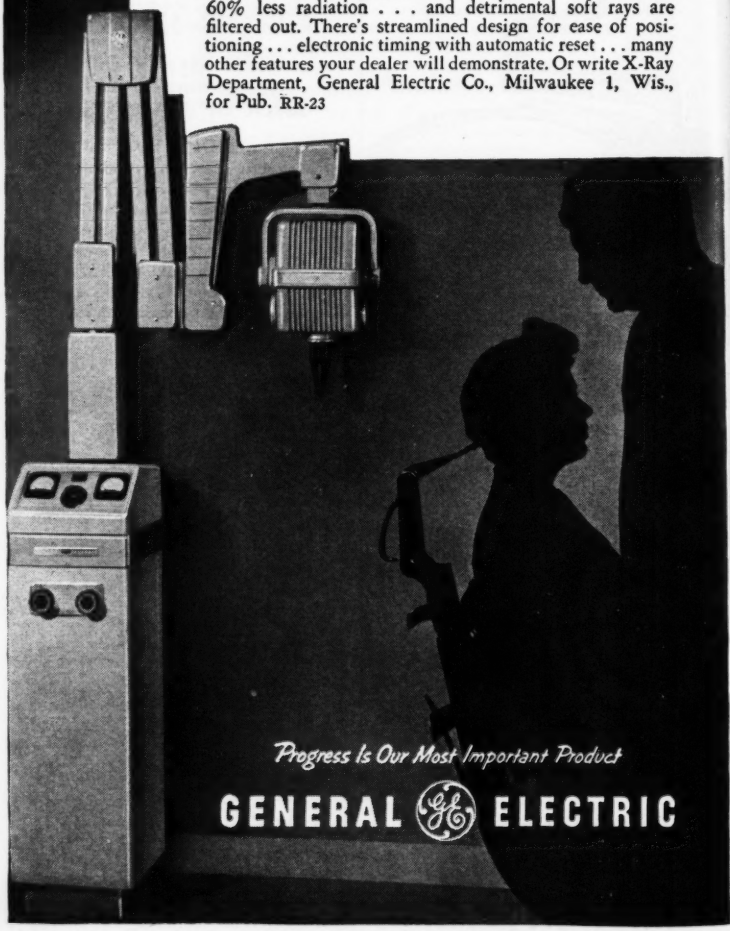

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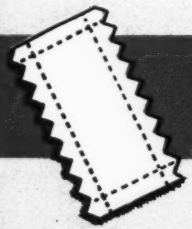

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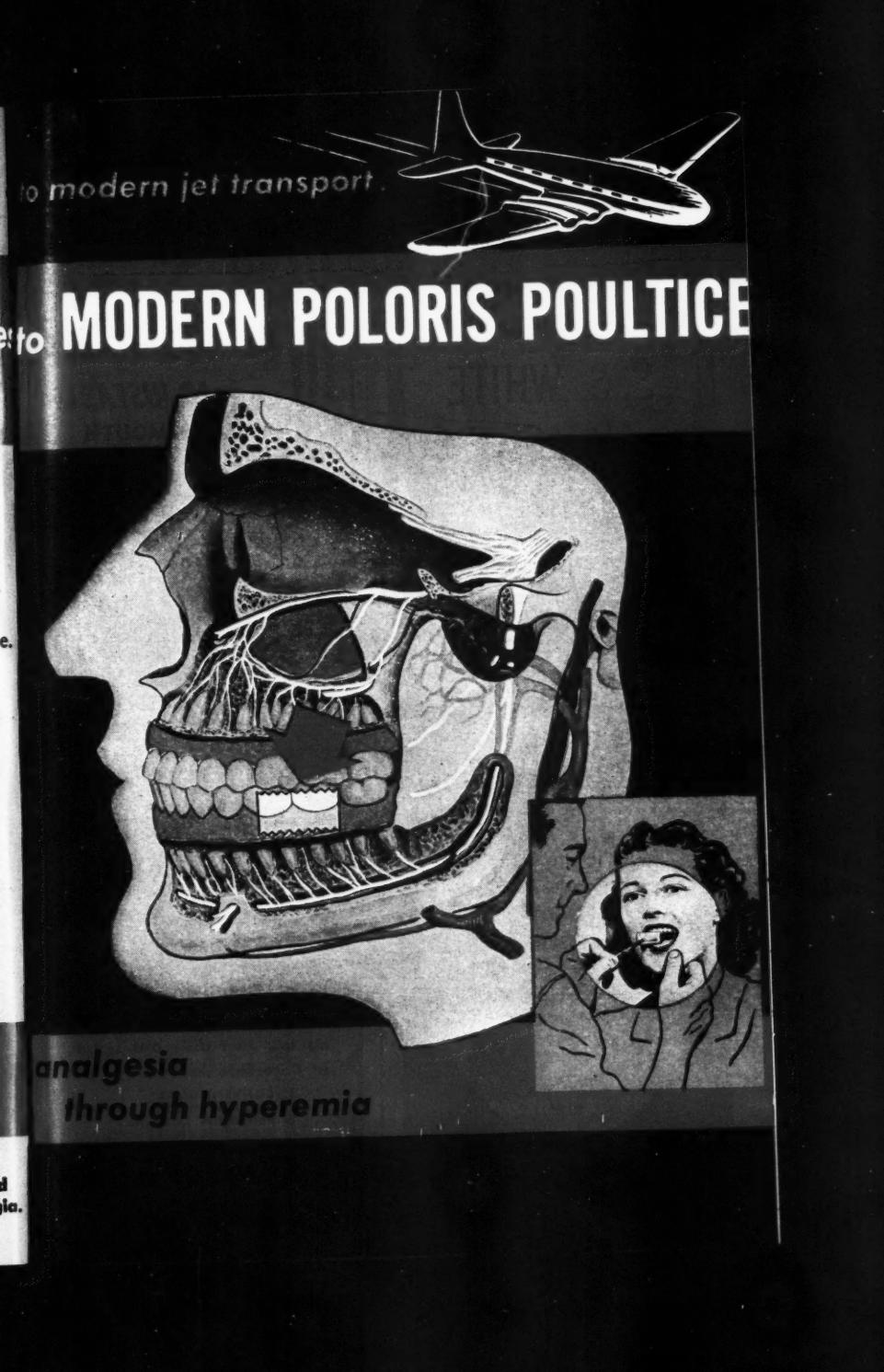
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Huldt, S., "Factors Influencing the Efficiency of Dental Local Anesthetics in Man", Acta Odontologica Scandinavica, Volume 11, Supplement 13, 1953.

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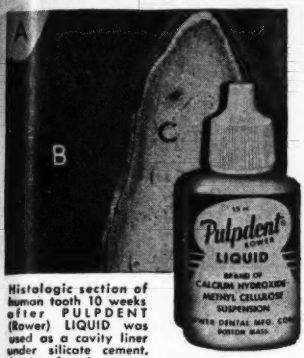

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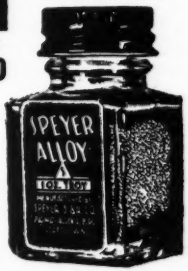

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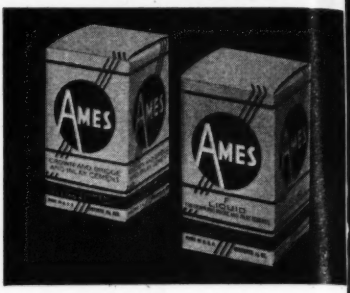

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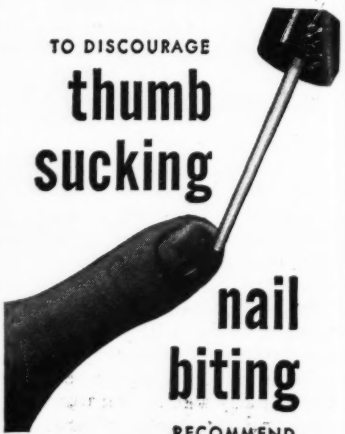

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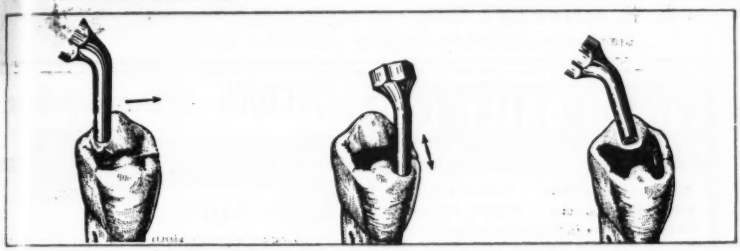

Apply Cavitip vertically, with very light pressure, until it has penetrated to desired depth. Extend preparation by moving tip laterally as illustrated.

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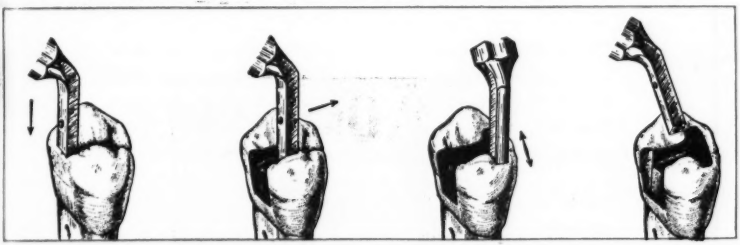


Prepare proximal box by applying Cavitip vertically; then establish occlusal floor by applying same tip laterally at desired depth in proximal box. Complete preparation by moving tip laterally as illustrated.

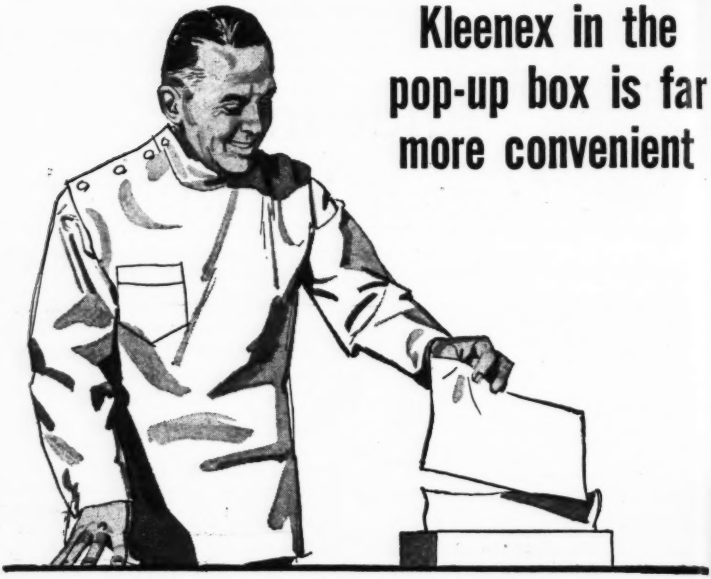
Each cut takes only seconds and produces smooth walls and floor, requiring no finishing.

"This is the fact that its routine use enormously reduces the fear and apprehension of the child patient, enables the operator almost to eliminate the use of anesthesia and makes it possible for the patient to accept, with comfort and without anesthesia, more actual dental work per chair hour than has been our experience with rotary instruments." *Zinner, D., and Whetstone, W., J. Den Child., Mar. 1956.*

"On the basis of histologic and clinical evidence, no unfavorable pulpal reaction resulted from the use of an ultrasonic cutting instrument for the preparation of cavities in the teeth used in this study." *Healey, H., Patterson, S., and Van Huysen, G., U.S.A.F. Med. J., May 1956.*

Ask your Cavitron dealer for a demonstration— or write for literature

CAVITRON EQUIPMENT CORP.
42-26 28th Street
Long Island City 1, N. Y.



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Buy Kleenex tissues by the case in the pure white professional box

Only Kleenex* tissues pop up to serve just one at a time. And now Kleenex comes in a pure white professional box designed especially for dentists. You can get either the extra large professional size or regular size Kleenex in this pack. Both are available in an easy-to-store case of 24 boxes. Keep Kleenex handy for dozens of office uses.

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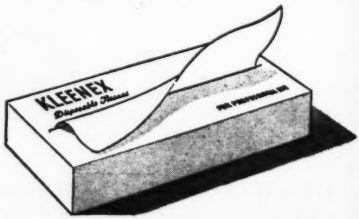
Professional size No. 5405 15″ x 18″



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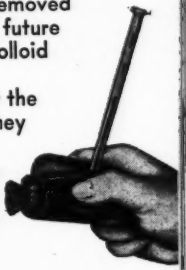
Each full-size stick of Perfectocoll is sealed in its own Latex mixing container which is in turn sealed air tight in a glass tube. Perfectocoll is boiled for 8 minutes in its latex container, then kneaded as it cools to 125°F. The aluminum clip is then removed to express the amount required and then resealed for future use. It also works perfectly in mixing devices and Hydrocolloid conditioners.

The 3/8" and 5/16" sticks are of a darker color and fit the mixing syringes designed for making inlay impressions. They come sealed in glass jars with preservative liquid.

You will be thrilled with the perfect impressions, the fine working-qualities of this latest, much improved Baker Perfectocoll. Order from your dealer, today!



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Perfectocoll

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A Small Investment that pays Big Dividends

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Complete Set $122.50
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(either upper or lower models)

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Complete set includes display case, upper and lower models of natural pink acrylic and three interchangeable cases for each, illustrating the following constructions—

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Gold and Porcelain
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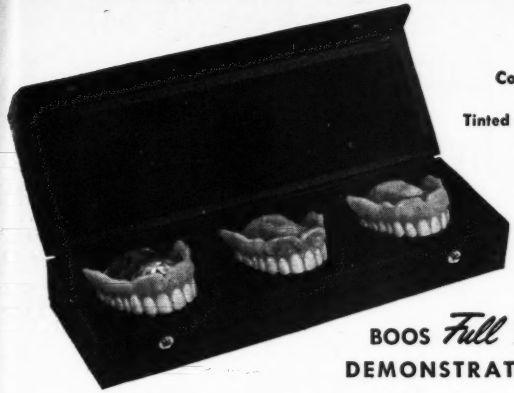
Gold Frames with Acrylic Saddles
Vitallium Frames with Acrylic Saddles
Surgiloy Wire Frames with Acrylic Saddles
Surgiloy Wire Frames with Gold Clasps
Gold Wire Frames with Acrylic Saddles

HENRY P. BOOS DENTAL
808 NICOLLET AVENUE



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4. They *show the patient* what his finished restoration will look like.

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...ORATORIES, Inc.
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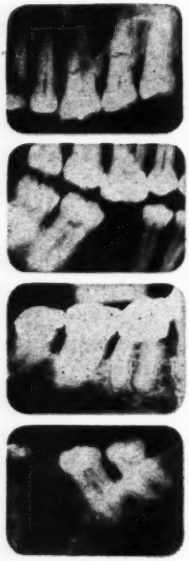
pain from hypersensitive dentine relieved in all of 92 patients[1]



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Often complained of, seldom controlled — that is the usual status of *hypersensitive dentine.* Until now, patients have had to depend on infrequent office treatments in the sensitive areas for relief of pain caused by contact with cold, hot, salt, acid, or sweet food.

NOW Thermodent Tooth Paste keeps proven corrective agents (salts and 1.4% formalin solution) *in daily contact with the offending surfaces.* Relief is evident in a week or two and can be maintained by continuing the use of Thermodent indefinitely.

1. Fitzgerald, G.: Dental Digest, 62:494 (Nov.) 1956.

Thermodent[T.M.]

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Now in color!

The "Wonder Electric Mortar and Pestle" is *now available* in rainbow colors to match your equipment and blend with your office decor. Here are appealing, soothing colors to please the most discriminating patient. Here is sound color psychology to work for you. Also available are new housings in these beautiful colors for reconversion of older Black and White models.

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Fine dental instruments are judged by the *high standards* you establish. To be sure of equal quality in a toothbrush for your patients, prescribe an Oral B.

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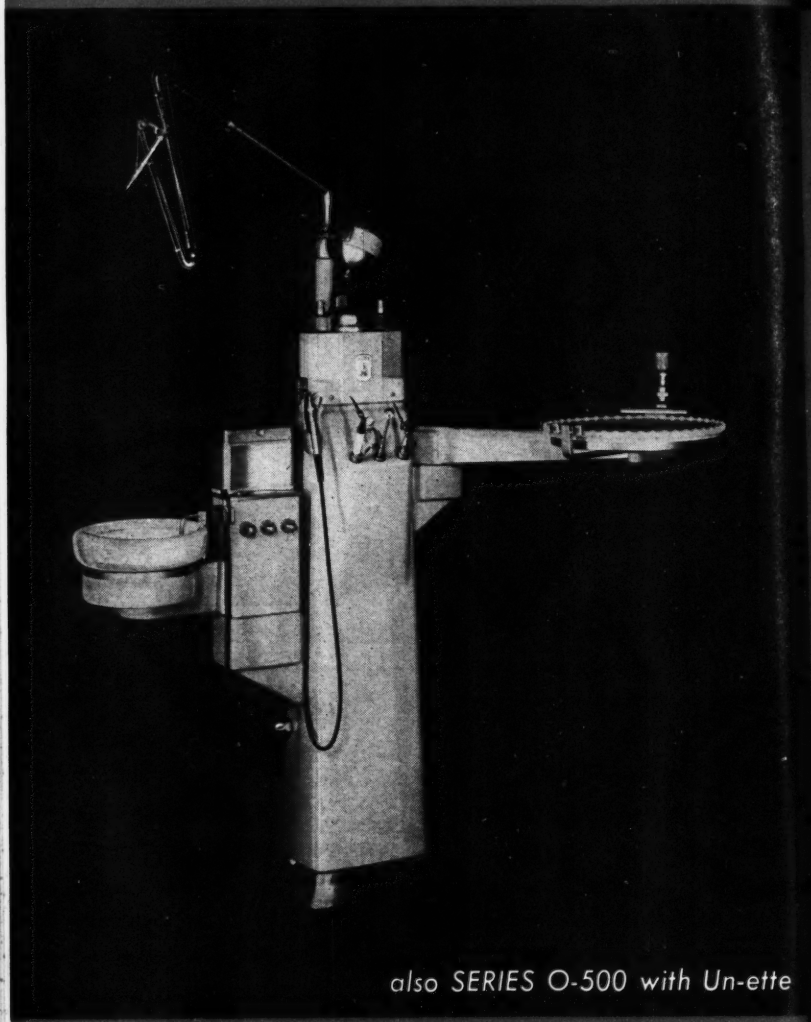

also SERIES O-500 with Un-ette

SERIES M500

Today's dentist recognizes that styling and beauty in the operatory are essential to good patient relations. In Series "M 500" the integration of high styling and practical utility lends dignity and ease of operation to the daily practice of dentistry.

The trim lines of the "Un-ette" type cuspidor, the enclosed drinking glass holder, the dual spray heater, the perma-mold aluminum base, the bracket table arm—modernity itself!

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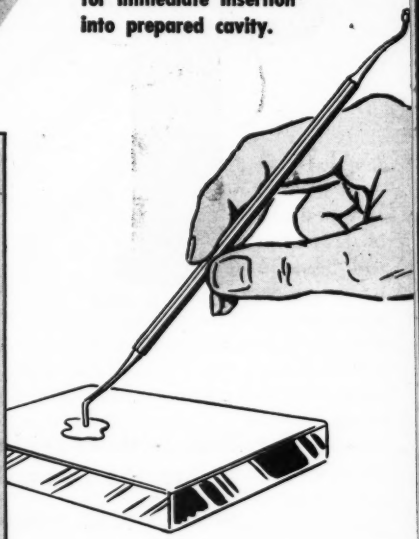
Temporary Filling Material

Supplied in wide neck bottles, "NO-MIX" is a thick paste ready for immediate insertion into prepared cavity.



- **Ready for immediate use — no mixing or warming required.**
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- **Supplied in jars of 23 grams.**

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For Instrument Disinfection

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BACTERICIDAL—when diluted with water (except the tubercle bacillus)

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PLUS—these other important advantages . . .

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HALIMIDE and your INSTRUMENTS . . . .
THEY COMPLIMENT EACH OTHER

Leading Anesthesiologists Say- "Aspirate!"

Now you can—

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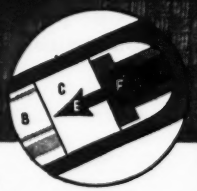

A — Syringe Barrel
B — Cartridge
C — Rubber Plunger
D — Piston
E — Harpoon
F — Harpoon Shaft

ASPIRATION is held mandatory by leading anesthesiologists, particularly in using highly potent, fast-acting local anesthetic solutions.

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- **Hollow Piston Rod containing Harpoon** which, when embedded in rubber plunger, retracts it to aspirate.

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Prices slightly higher in the Far West.

Your patients particularly will appreciate these modern techniques to reduce the radiation in your office to a tiny fraction of what it is at present.

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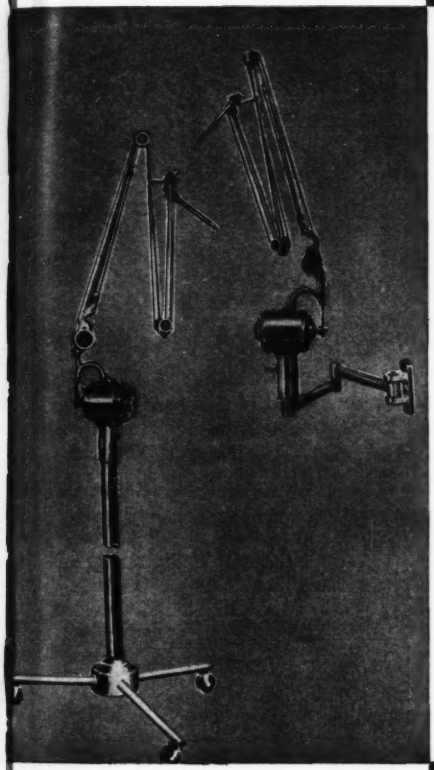

Keep your high-speed handpiece mounted on your unit . . . and install an EMESCO Engine—Wall or Floor Model—for work with your conventional handpiece.

You'll be amazed at the low cost for so much added convenience!

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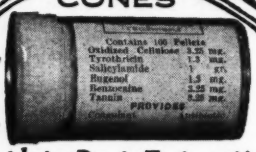

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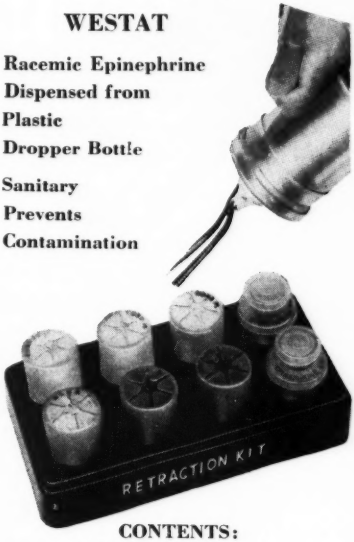

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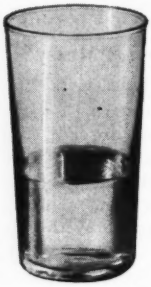

you add just a few drops . . . to a quarter glass of water

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